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Significance of F.E.R.A. Programs to Public Health Nursing

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The Significance of F. E. R. A. Programs to Public Health Nursing

IT is just a year since the first rulings affecting the care of the sick on relief were issued by the Federal Emergency Relief Administration in Washington* to be followed in November by C.W.A. and C.W.S. projects which were aimed to put people, including nurses, back to work. As we look over the events of the past year the measures for relief divide distinctly into two categories as they relate to public health nursing, the first, efforts on the part of the Government to see that those on relief who were ill received medical and nursing care (thus recognizing for the first time in history that nursing care of the sick is a part of an adequate relief program and therefore a legitimate lien on public relief funds) and second, the initiation of far-reaching state projects concerned with health to employ upwards of 8,000 unemployed nurses, more than two-thirds of whom have been working in public health projects.

What is the present status of these two developments and what lessons have grown out of the experience? It is still too soon to evaluate the end results of the whole, as many of the state projects are still continuing, but we can at least summarize events thus far and the ground lost or won as the N.O.P.H.N. sees it.

Rules and Regulations No. 7 (permitting payment from relief funds for nursing visits to those on relief who are ill) has been used extensively in a few eastern states, in scattered communities in other states, and not at all by the majority of states. As a rule in states where its privileges have not been called upon, there were other plans under way, or as in rural areas, another set-up answered the need, in some communities physicians failed to use the service and in several states in the East, money from the state or local relief funds was not forthcoming. It is important to note, however, that in general wherever this plan of care for the sick on relief has been followed, the administrators of relief have recognized the wisdom of payment of tax funds to private agencies on the basis of service rendered, have accepted the N.O.P.H.N. recommendation that where organized community nursing services already exist, these should be used in preference to the setting up of new staffs, and have seen, we believe, the advantages of dealing with an or-

*Rules and Regulations No. 7. Government Printing Office, Washington, D. C.

ganization in preference to dealing with individuals. At the present writing (September) there is little evidence of new activity in the adoption of Rules and Regulations No. 7. This is doubtless because state relief funds are low.

Turning to the second phase of the use of funds and public health nursing, what has been the effect of employing nurses paid from State E.R.A. funds? Here we see every variety of development. For the purpose of this article, we are discussing only those nurses employed in public health projects.

(1) There are states in which nurses have been assigned to existing public health nursing agencies, public and private, introduced to the field by their supervisory staffs (and for many nurses this was their first taste of public health work), supervised by them and in some cases absorbed by them to the point of becoming regular staff nurses. This additional help to agencies came at the moment when it was most needed to tide over the winter work in what might have proved a crucial situation with the mounting case loads, reduced staffs and budgets.

(2) There are states where nurses are developing public health nursing in areas where it never existed before. In some cases these nurses have been assigned to counties and sent out to sink or swim with very little supervision or help from any one; in some rural states the nurses are working out under the regular state and county health department staff, in others (also rural) where no state or other supervisory staff existed, there has been established from State E.R.A. funds a special public health nursing supervisor and field staff.

(3) There are states in which nurses are employed as relief workers under the supervision of the relief administrator.

(4) There are states in which the nurses while a part of the relief set-up, remain for supervisory purposes under the health department.

(5) There are states where the nurses are on the relief staff and are *supplementing* the regular county health program but carrying only those families on relief.

(6) And there are states where the former public health nurses serve the same counties as before, but are paid by relief funds. These nurses would otherwise have been dropped from their jobs. They have added relief to their programs.

However, the service may be administered—and there are almost as many variations as there are states—two tremendous gains have been made. At a time when curtailment has been the order of the day, E.R.A. funds, Federal and state, have meant the extension of public health nursing through existing agencies and in territories where no public health nursing existed before. Also, there is continued evidence that this recognition of the importance of public health nursing in the present crisis is building a firm foundation for further private and public support and certainly is creating a desire for a permanent public health nursing service in those areas that have experienced it for the first time.

The N.O.P.H.N. has continued and will continue to stress the three safeguards to standards in all use of nursing in relief projects.

(1) That a professional committee review the qualifications of nurses being placed in public health projects.

(2) That supervision by a qualified public health nurse be given by existing agencies or arranged for from relief funds.

(3) That nurses be assigned to existing agencies if any exist to avoid the setting up of duplicate machinery.

TYPES OF PROJECTS

Here again we find a wide range of interest, a vast variety of methods and the greatest imaginable difference in scope, regulations and—we presume—results.

In many eastern states the "relief" nurses are supplementing the work of organized city and county staffs, rendering invaluable assistance in both the bedside service and the preventive work.

In a surprising number of communities a family health service including bedside care, not always limited to those

actually on relief, has been started. In some states the special projects are those sponsored by the U. S. Children's Bureau covering all phases of child health—the emphasis being on the school child. Also, statewide, county-wide and intensive surveys have been made by these nurses on such conditions as diphtheria, smallpox and typhoid immunization, vision testing, crippled children, malnutrition, dental caries, hookworm, pellagra, etc., classes in home hygiene and care of the sick have been offered, prenatal and infant welfare conferences started, and tuberculosis contacts surveyed.

STAFF EDUCATION

Naturally, one of the greatest problems facing the supervisors in this mushroom-like growth of service, was the problem of introducing and preparing the nurse for her job. Many of the applicants had never had any public health nursing experience, a few little experience of any kind, but all were expected to shoulder the new job and make good. The dread that all public health interest and effort might be killed in a community by an initial unhappy experience with an inexperienced nurse, was in every supervisor's mind.

It is therefore greatly to the credit of all concerned that staff education plans started the moment the first relief nurse went on duty, and have continued in various forms to date. Regular "introduction to the staff" was given whenever time and facilities permitted. Conferences—individual and group, regional meetings, statewide meetings, reading lists, traveling libraries, N.O.P.H.N. material—all sorts of ways have been used to help the nurse in her work. Staff education programs need to be continued and developed wherever projects are still under way, whether these be formal or informal, and the N.O.P.H.N. has suggestions along these lines that have proved helpful to state groups.

NEXT STEPS

As we face a new winter of uncertainty, constant care needs to be exercised to see that the emergency program supplements, but does not take the place of existing health programs, and to resist the temptation to hand over the established health program to the emergency relief administration just because it has, at the moment, more funds. We still regard the emergency relief program as an emergency in the sense that it is planned to meet the present situation and not to take over the entire responsibility for the established health and social programs planned for the whole community. Whatever is done for the sake of expediency, care should be taken that it does not jeopardize the future. Therefore, with all the unavoidable emphasis on material relief, it is essential that this one human need should not swamp public health work or workers.

Where no public health nursing service existed before the depression, effort might well be made to strengthen the emergency public health nursing program by developing lay advisory committees to give community backing. The interest of representative citizens and the appreciation of key people of what a public health nursing service can accomplish for their community will do much toward establishing such a service permanently.

Out of the past year's experience new policies have been accepted, new experiments tried out, new services started, new nurses recruited to public health. We have managed to remain flexible—we hope—always keeping in mind the standards and safeguards that experience has shown produce the most effective and far reaching results. We do not—cannot—know the best final answer to every new question, but we have learned enough to guide us in next steps and sound fundamental principles.

Program Planning in Relation to Budgets

*In an Official Health Nursing Service**

By AMELIA GRANT, R.N.

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THE first question which comes to one's mind in relation to this subject is, what is the difference between the official health agency and the private health agency? The differences are not striking but there probably is some difference in responsibility toward the community. To the official agency is delegated the responsibility for the protection of the health of the entire community. If it does not actually provide, or administer, all the services required to safeguard the whole population adequately, it must, at least, know that such services are provided, and by whom they are provided. The official agency should take leadership in planning the community health services so that all money and energy expended will be for those activities relatively most productive in terms of better health.

The success of the work of the official agency is measured by improved health conditions for the entire community. Such health conditions are usually expressed in the community sickness and mortality rates.

The budget of the official agency depends upon the community's appreciation of the public health service. Public opinion controls the appropriation, and health work finds its place in the budget according to the value put upon it by the citizens. This is a somewhat different method of raising money than having it done by a select and experienced group of people who are particularly interested in some special health activity. There may be a certain security in the public budget for health work but there are apt to be limited appropriations in proportion to the services actually required for reasonably adequate health protection. Therefore, careful planning is necessary in order that the available budget may provide the best possible service.

THE TREND TOWARD OFFICIAL CONTROL

We are told that, at the present time, there seems to be a definite trend toward placing greater responsibilities for the administration of health work upon the official agency. It is hard to tell whether this trend expresses a different philosophy in regard to health service, or, whether it is a way of meeting an emergency. Is the work being turned over to the official agencies as a result of reasoning and the conclusion that health work, like education, is a primary function of government, and that these services in a democracy are rightly placed under governmental administrative control, subject to community-wide planning and support, or, has it become necessary to rely upon public funds because of the losses in private contributions? For whatever reason, the fact remains that the official agency is being called upon for more service and its budget problems are being increased. The soundness of the health organization and the wisdom with which the budgets will be adjusted, depend somewhat upon the public mind in regard to the official agency's real responsibility for health service.

ADJUSTING THE PROGRAM TO MEET THE BUDGET

We survey the various activities to try to find which things are fundamental, in order that the most important things shall be done first. The importance of each service is readily justified. There is no question concerning the

*Presented at the N.O.P.H.N. Round Table for Nurse Administrators, Biennial Convention, Washington, D. C., April 24, 1934.

value of communicable disease control or the care of the younger age groups, or, in fact, any of the established activities; but it is very difficult to classify with accuracy these health activities according to their relative importance, and the limitations of the services to the most fundamental problems at once become a very complicated matter.

CHECKING WASTE

Before limiting activities either in scope or quantity, every wasteful procedure should be found and eliminated. In order to check waste a thorough knowledge of the service is necessary, and more than ever we need an adequate statistical service, for without such service the nursing work can not be analyzed in sufficient detail to find the wasteful procedures.

STUDYING THE SERVICE

Case records must be carefully studied to know how many visits to a home, or to a clinic, are made for various types of cases, and with what results. Is the home visit effective in a diminishing ratio after a certain number of visits are made and, if so, how many visits are reasonably profitable? Are the purposes of home visits specific and is there evidence that the visiting has accomplished these purposes? Can parents be given greater responsibilities for the health of the family? Do they accept the responsibility and take more initiative in seeking help when needed? Do they sometimes come to the nurse at the health center rather than have the nurse always take the time to visit their homes? Is the service properly distributed among the people needing it, or do a few people get a rather intensive service, perhaps assuming very little responsibility themselves, while others in the community receive little or no attention? Is it possible to distribute the service more widely with as good or better results? Are time and energy spent primarily for the prevention of disease in so far as we have scientific knowledge upon which to base an effective program of disease prevention, or are they spent too largely in caring for disease and correcting defects which need not have occurred? For instance, are thousands of visits made to diphtheria cases and relatively little time spent in securing immunizations against diphtheria? Is such a large proportion of available time spent in finding and diagnosing physical defects that there is little left for securing corrections of these defects? Are countless home visits made to persuade parents to have defects corrected when the community resources are so definitely inadequate that no amount of home visiting could be productive? Is much time spent in caring for children between two months and one year of life when the high infant death rate for babies is under one month of age, without a definite plan for reaching these babies earlier in life? In other words, is the service rendered studied and controlled so that all time and effort are placed where the greatest return can be expected?

CONSERVING NURSE TIME

Another problem for the administrator is the use of nurse time. Are nurses expected to give their time to those activities which can best be carried by someone having the professional training and experience of the nurse, or are they asked to perform many non-nursing duties which could be assigned to clerks, aids, or volunteers, whose services may be less costly than the nurse's and by whom the work may be better done because of their training for the particular type of work? Are nurses given adequate health protection, or do they work long hours and attempt to carry too great a volume of work? Sometimes overwork and lack of health service for the staff result in high sickness cost to the organization. Sickness costs to the organization are noted in loss of time and lessened efficiency of the service to the people. Besides, sickness usually increases the supervisory costs because of necessary changes in personnel.

How much time is used in travel? Does the organization know? Could this time be reduced? Would it be an economy to provide automobiles for nurses in districts where transportation

facilities are not good? Not only the nurse time but physical energy expended for no direct benefit to the community may be very costly. Economies should be studied and practiced because they are known to be real, not just apparent economies.

Is the amount of time spent by the nurse in record keeping reduced to a minimum? Very often service organizations attempt to keep rather elaborate records believing that the information contained in such records may be wanted for certain studies. Is it wise for every service agency to attempt research in the various branches of the work? Would it perhaps be better to have such studies made as special projects with a definite plan for using all the data which the nurse is asked to secure? Records routinely kept by a public health nursing organization should provide the minimum detail necessary for efficient administration and satisfactory care of the individual patient. Much time can be spent in keeping detailed records which will never be studied. Every unnecessary procedure should be eliminated from the nurse's daily program.

SAVING IN SUPPLIES

Every one believes she is economical with supplies, but in every large organization there is, without doubt, a considerable amount of waste. Each worker may have only the slightest wasteful or extravagant habit, but the total waste is high. Printed forms are used for purposes other than those for which they are intended. Records are copied because carelessly kept, thus sending up record costs in additional forms and nurse time. Wastes too small to attract the attention of most individuals as they work may seem very important when multiplied by a large number of workers. More conscious effort to eliminate wasteful practices will help.

STUDY THE COMMUNITY

The community should be studied in the same way that individual case records are studied, to find where there is overlapping in service; where there are wasted effort and lack of discrimination or thoughtful planning in the distribution of the service. The machinery of coöperation should be so simplified that it is easy for agencies to work together without a loss of time and effort. If services must be curtailed, it is more important than ever that two nurses are not both doing the same thing and, perhaps, this thing less well than one would have done it, because there is duplication, confusion and loss of effort.

MAINTAINING THE QUALITY OF SERVICE

Eliminating waste need not reduce the quality of service; in fact, it may improve the quality of service. The results obtained through a service which is efficiently administered, will probably more than justify any small additional cost for administration. It is, therefore, not an economy to cut the administrative service—this includes nursing supervision, records supervision and statistical service—to a point where intelligent planning for more efficient and less wasteful service is impossible.

CUTTING SALARIES OR CUTTING PERSONNEL

Finally, after all the wastes have been carefully checked, the organization may have to face the question whether it will have to cut salaries or cut personnel. As a rule, nurses' salaries have never been high. They were not high in proportion to other professional workers even in those days when salaries for everybody were considered good, and there is grave danger in reducing salaries too low. It will be impossible for an organization to attract and keep the right kind of nursing staff if the salaries are not commensurate with their professional training and adequate to meet a standard of living accepted for professional people. Moreover, no one small group in a community should bear the cost of the health service for the community. It seems that, in the long run, the wiser course is to cut personnel, and to cut service to the public, rather than reduce salaries to a level which will tend to lower the standard of service which can be

provided. The community can only be aware of the cost of a service when it pays fairly for that service, and not when a considerable portion of the cost is met by the group rendering the service. It is necessary for a community to appreciate what a reasonable cost for a nursing service is, since public opinion controls the budget.

EFFECT OF RELIEF PROJECTS IN PUBLIC HEALTH NURSING

With numbers of nurses available without cost to a given organization, there is sometimes a tendency to widen programs and to extend services without sufficient community thought or planning. This will, no doubt, result in duplication of services, or in confusion, which will tend to limit the value of the services. Moreover, certain agencies have taken on many nurses paid from relief funds without providing adequate supervision for these new workers and without any thought as to the number of new workers in comparison to the already existing staff. The administrative machinery may not have been adapted to this larger and suddenly increased personnel. Such practices tend to bring a certain amount of dissatisfaction with the entire plan.

Problems which may arise because of taking too many new workers into an organization without providing adequate supervision are obvious. The standard of service may be lowered; public opinion, in turn, will be affected by this lowered standard of work. Quite as serious a problem arises when all of the available supervisory service is required to meet the needs of these new nurses and the regular staff must be deprived of that kind of supervision and leadership which they need for growth in their work. The whole development of public health nursing of a high quality may be affected by this lack of supervision.

Nurses need work and the community needs nursing service. It should be possible to make these ends meet without creating serious problems. The nurses on relief projects should be assigned to various services according to their special abilities and experience, and there should be adequate supervision for the project. If necessary the cost of this supervisory service should be included in the project. Further, the needs of the community should be considered in determining the work to be done by this increased staff, in order that the service may not be impractical and of relatively little real value.

With reasonably good selection of staff and proper supervision and intelligent community planning, the individual nurse, the community, and the organization will profit, but without these safeguards such programs may be building very real problems for all of them.

SUMMARY

In summarizing I would say that, in adjusting a program to a budget, whether in an economic emergency or in more normal times, the first thing to do is to study the service, find the wastes and eliminate them; prevent overlapping and duplication of service; the careless use of supplies; distribute the service wisely; serve as many people in the community as it is possible to serve and eliminate all wastes in home visiting by having a definite purpose for the visit and studying the effectiveness of the visit; conserving the nurses' time for strictly nursing functions and save unnecessary costs of sickness by reasonable health service for the workers. If it is necessary to cut services in order to balance the service carried and the staff provided, such cuts should be made, rather than reduce the nurses' salaries below a level reasonable for professional salaries. The community should pay fairly for its nursing service and should know how much such service costs. Reducing the supervisory service as a means of adjusting the budget is probably unwise planning. Such cuts in supervision may leave the staff without adequate leadership through situations caused by the economic depression and more trying than usual. Reducing supervision to a point where staff education is entirely neglected is probably building future problems for the organization. If relief workers are used, and without doubt they should

be, certain safeguards are necessary to make the service of real value. Community planning for public health nursing is always needed. There should be a maximum of intelligent coöperation. The work of one organization should be carefully considered in relation to the work of other organizations, in order that there should be no overlapping, or duplication.

Program Planning in Relation to Budgets

*In a Non-Official Agency**

By RUTH W. HUBBARD, R.N.

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DURING the last few years we have been through what may be called three phases in budget planning in private agencies. Now, it seems to me, we are emerging into a fourth and more progressive period. To review these briefly will perhaps give us a background for our discussion today of this fourth phase.

PULLING IN THE BELT

Back in 1930 our first reaction to decreased incomes may be described as the pulling in the belt period. We talked about an emergency and we made what were called temporary adjustments. Agencies spent sparingly, bought fewer supplies, refrained from purchasing cars and new equipment, watched current expenditures carefully, and in a word—went without. The attitude was that of holding off until next year. Volunteers were recruited and urged to help regularly in health centers, record offices or motor corps. Their intrinsic value to an agency, as well as their financial aid, was realized afresh. But actually no great policy changes occurred.

CUTTING PATTERN TO FIT CLOTH

Then came 1930-1932 and the second phase when we had to cut our pattern according to our cloth. We still talked about an emergency and a temporary interlude, but more radical changes were necessary, so salary reductions and program changes made their appearance. Since staff budgets constituted our largest expenditures, no great reductions could be made without affecting salaries. Elimination of vacation substitutes, failure to replace resignations, vacation adjustments, were coupled with salary reductions and administration savings to prevent deficits. Fear characterized the retrenchment in some places and the reduction or elimination of certain services was not always farsighted. Some of the activities were properly dropped, but here and there the so-called non-vital services have proved to be truly important. At this time we began in many places to be more keenly aware of our relationship to the whole community in planning budgets as well as in service. A new sense of unity appeared which has borne fruit recently.

SELF-ANALYSIS

With the arrival of 1933 we entered the third phase. Fear receded and an attitude of honest analysis appeared. We were willing to look at our own programs in relation to the services offered the entire community. We asked ourselves frankly certain vital questions. What part of our work is important to our community? What part only to ourselves? What activities can go because they are in the experimental stage only? What other parts need expansion? What does our community expect of us and how can we best meet those expectations? During this period joint thinking developed richly. Within agencies board and staff worked out many things together. At the same time the inter-agency relationship was strengthened and chests and community councils proved that they could work

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together wisely for community welfare in difficult times. Associations undertook to think through the basic program in public health nursing and build their own accordingly. At the same time a new feeling crept into the budget committee meetings. Agencies began to think in terms of wise spending of principal in some instances as well as income. They sought new sources of income. They scrutinized salary reductions carefully, remembering that the staff is the backbone of the program.

FACING FACTS

Before all of these changes were wholly accomplished the fourth period dawned with the new year 1934 and the challenge of a new era. This is where we find ourselves today, and it is here that our discussion centers. Out of the anxieties and apprehensions of the earlier periods we have emerged into a phase in which frank and courageous facing of a situation is the order of the day.

The public health nurse has become an important figure in the community because, convinced of the soundness of her basic principles of community and family service, she has always been able and willing to adjust or improvise in a situation to insure the achievement of that service. Now the public health nursing organization determines upon its basic principles likewise, and proceeds to improvise to make their achievement possible. High quality of service, adequate for the community without overlapping, evincing that true coöperation which willingly submerges identity, forms the basis of a program which plans to reach its objectives. The staff members are our service to a community. We know that their preparation, their continued professional growth, the safeguarding of their health, a proper return in salary, the sharing of field responsibility as they become experienced, all constitute vital factors in the quality of service they render.

We are learning to build the program on the community's acknowledged needs, together with those existing but unrealized needs which should be met for the future welfare. We want to reach all who need us and not selected groups only. We must do our spreading thin wisely by making every visit thoroughly worth while to the patient and family. Visits themselves may be longer but can be spaced. Health center appointments are valuable if they are really helpful to the patient and so justify the elimination of a home visit. As never before we must be equipped to meet emergencies which may appear as epidemics, new demands from patients, or new Federal programs. This may constitute responsibility not alone for service but also for the preparation of workers in new and affiliated Federal, State and local projects. It emphatically means concrete planning for the future.

CONCRETE PLANNING FOR THE FUTURE

To undertake this wisely we must think of our resources as well as our service. Can the accepted sources be stabilized? Does the new era call for new attitudes toward reserves? New sources are open for cultivation, as new patient groups, industries, public funds.

An analysis of one program points to some improvisations and makes certain suggestions. Careful expenditures may prove more saving than scanty outlay. Additional clerical help sometimes produces more field nursing time. An analysis of records and their uses may mean wiser recording. A better filing system may mean more efficient use of records. Better individual teaching may suggest health center appointments and the reduction of home visits. A mental hygiene supervisor may add immeasurably to the nurses' equipment for wise handling of difficult problems. Continuous staff education can reduce inadequately handled field problems. It will certainly give knowledge and courage to those who daily meet new and perplexing field needs. A steady and continuous, rather than a sporadic analysis of each part of the association's program by joint board and staff endeavor is the basis of true progress.

What is the golden key? No organization can set up a schedule for another. The local situation will always deter-

mine the program. The preservation of an expensive delivery service may be vital if a particular community is to reduce its maternal mortality rate. A certain project may be sufficiently well developed to make an important contribution if completed, although its beginning in a new situation would not be approved. Amalgamation and integration may come more readily in one place than in another.

REMEMBER!

Building on the experience of the last few years, as we plan our budgets for the future, several things may be borne in mind:

Let us look outside our own organization to the community in which it exists and weigh its place therein fearlessly and honestly.

Let us do everything we do well, for poor work is always expensive and unsatisfactory. This means a well informed, interested, active board; a well prepared, eager, appreciated staff; and well served and understood patients. These patients may be visited less frequently, but they will have been taught how to proceed between the nurse's visits and they know that when she does come the nurse always has time to be of real help. It means in addition the provision for the staff of efficient tools and transportation, adequate clerical assistance, cheerful office environment, and steady, stimulating, understanding supervision. Let us spend wisely, wasting neither time, effort, personnel, equipment, money nor energy.

In a changing world let us avoid a static point of view, cultivating a readiness to change a service or its character if the field needs require it. Every part of the whole must learn to stand or fall upon its own merits and its value in the entire situation.

Finally, let us plan with courage, vision, and a spirit of adventure. May it be the same spirit of adventure for service which first led the nurse out of hospitals into homes and thence to schools, infant welfare centers, industries, and on to that ever widening field called public health nursing which embraces the entire life of the family in the community. This courage, adaptability, and adherence to standards will lead us with our boards to the new, more complete and unified service for public health which is our desired new era of the future.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR OCTOBER

Lay Participation in Social Work from the Point of View of Public Agencies *

By HERTHA KRAUS
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WHILE lay participation in private social agencies is an old and established tradition in this country, public agencies have been somewhat reserved in following it. In the public health and probation fields some agencies have found the coöperation of volunteers most helpful but only a very small number of public relief agencies have dared to experiment along the same lines. Houston, Dallas, Nashville, Denver, Columbus, Detroit, Buffalo, New York City, and Westchester County, among others, have expressed their satisfaction in working with interested laymen and pointed the way for various possibilities. Yet in general, public agencies in this country do not seem convinced that there is a real place for the volunteer in their set-ups. There is some feeling among certain public agencies that lay participation may increase public criticism of their policies or even result in undesirable political interference. Other agencies feel that while there may be a real demand for the volunteer in times of emergency, and for temporary services during catastrophes, the more permanent structure of a public welfare system does not call for coöperation.

VOLUNTEERS AS A PART OF THE PUBLIC WELFARE SET-UP IN GERMANY

A brief survey of the methods of volunteer service in public agencies developed for more than three-quarters of a century in another country might possibly be helpful in contributing background experience. I am referring to the German tradition of using large numbers of volunteers as part of the public welfare set-up.

The German systems of organizing volunteers for public work, internationally known as the Elberfeld and the Strassburg plans, are in the main concerned with continued volunteer service to individuals and families. In both systems, the volunteers are organized in neighborhood committees under volunteer chairmen. The total of these committees cover the entire area of a community and each committee deals with social service to be rendered in their immediate neighborhood. The main charge of the volunteers is the care of dependent families, and children in foster homes under public guardianship. Every volunteer member of such a committee assumes practically full responsibility for the clients assigned to him, working in close contact with his neighborhood committee and the professional staff of the public agency.

NEIGHBORHOOD COMMITTEES

Neighborhood committees meet regularly once a month and discuss policies and individual cases with the visitor from the public agency assigned to the particular district. In the original set-up the volunteer is allowed to carry only a very restricted case load of not more than four families.

While some participation by respected citizens, mostly business men, was quite usual and traditional in the public social work carried on by the German cities in the early part of the last century, the idea introduced by the mayor of Elberfeld in 1853 centered around the organization of small and numerous neighborhood committees and the restriction of case loads so as to really safeguard personal contacts with clients.

This innovation helped to cut the cost of poor relief in Elberfeld more than

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fifty per cent within the first six months of its operation and was quite in accord with our present conviction that ultimately individualized work is more economical than the mass approach.

The main difference between the Elberfeld and the Strassburg system is in the relative standing of the professional worker as compared to the volunteer. In the original Elberfeld system the work of the paid staff of the public agency was more or less confined to clerical tasks and accounting, representing the office end of the volunteer social service units, and some general supervision of these units. Later developments proved the need for an increasing amount of professional service, leading to the so-called Strassburg plan. Under this system, professional workers representing the public agency were made members of the volunteer neighborhood committees and, in some cases, their chairmen.

While the Elberfeld system left the entire intake to the volunteer groups, the Strassburg system allowed the intake to be handled by the professional staffs. The visitor notified the committee of practically all cases opened or reopened in this district, yet only selected cases, rather than the entire case load of the agency, were placed under the care of volunteers for temporary or permanent service.

In most communities these committees helped to select cases suitable to be transferred to the charge of the volunteer and referrals were made more and more on the basis of the individual qualifications of the volunteer for the specific service needed, rather than on purely geographical considerations.

VOLUNTEER SERVICE ON A LEGAL STATUS

In both these systems, the volunteers as individuals and the volunteer neighborhood units had a legal status in the public agency's set-up. The volunteers were appointed unpaid officers of the city council and the neighborhood units functioned as sub-bureaus of the public agencies, sometimes with informal offices in the home of each neighborhood chairman. Frequently experienced chairmen were invited to serve on the public agency's central advisory board.

In the more modern form of the Strassburg plan, lay participation has survived all changes in legislation and administration in German communities. In most cities, the volunteer staff of the public agency is approximately three times the size of the paid staff. Members of the volunteer staffs are, to a large extent, men and women of mature age. Many are retired business or professional men, or mothers of older children who find satisfying use for their leisure time in doing social service. They are appointed for terms of service varying from three to six years, but very frequently continue such service for several decades.

Volunteers consider their service as a public function and are listed as honorary officers in the official statements of the various cities. It is evident that the type of service just described is very closely related to the German concept of government as an organized representation of civil efforts, a responsibility shared by many full-time and part-time workers, salaried and non-salaried. The fundamental approach is somewhat different from the tradition in this country where, up to recent times, government has occasionally been considered as a necessity to be tolerated and consequently limited as much as possible.

A DIFFERENTIATION OF JOBS

A close scrutiny of the trends of development of lay participation in German public social work brings out some points which may have bearing upon current problems of American social work.

As to the functions of the volunteer workers it seems that their services have been successfully integrated because their job was visualized as being distinctly different from that of the professional. Close and continued contact with clients on the basis of friendly visiting, and meeting their varied requests for consultation, was considered the volunteer's privilege—and not a service which should be assigned to the professional, paid staff of the *public* agency. The ever-present need for economy and

the responsibility of the public agency towards its supporters to render the best service with the least expenditure has restricted the trained and qualified case worker's function in many ways.

The case worker has been expected to concentrate, in the main, on major service cases. Besides this, she assumed responsibility for such duties of intake, diagnosis, and treatment of all other cases which seemed to call specifically for the trained person. She developed methods of wisely supplementing the volunteer's service to his families by direct, or preferably indirect, skilled service. Yet many professional workers have learned that this supplementation is not needed as frequently as they expected. After some years of experience, they would readily agree with Mary Richmond's statement that "the ability to turn to good account the services of the relatively untrained is the supreme test of the trained workers." Also that "the higher the standards of professional service, the more good friendly visitors there will be."*

Schools of social work rendered a distinct service to social work at large and especially to public agencies if they succeeded in imbuing the students with this spirit and strengthened their ambition to apply it in their daily work.

The task of providing individual and personal service to all clients, even when there were very large numbers of them, could probably not be solved in any wiser way than by mobilizing and directing all vital forces in the community for just this purpose. In this way service has been fairly secure even in times of sharp budget cuts and lay-offs when mass needs swelled relief expenditures while taxpayers were least ready to meet them.

It has been proved, too, that organized volunteer participation, preferably on the basis of neighborhood units, helped to check waste and increased the efficiency of relief giving.

PROFESSIONAL ASSISTANCE TO THE VOLUNTEER

Public agencies, as much as private, owe to the volunteers an introduction to the problems they are going to face and some help in selecting their methods of approach. Of even more outstanding importance has been the continuous direction of the entire volunteer service by the professional staff and their responsibility to help the volunteer relate his experiences and interpret them in their wider implications. Only when this help was carried on in a planned way have volunteers developed into the agency's best interpreters to the community.

It is not necessary to explain in detail the invaluable contributions of large volunteer groups to the community's understanding of the needs and methods of public social work. Not only do the volunteers themselves, but also their families and friends, become informed and interested so as to build up what all agencies need so desperately, an intelligent constituency—a constituency ready to act as a defense group if occasion arises; ready to give constructive criticism; and ready to help support, through adequate taxes, the service of the public agency of which they are a part. Ready also to support by way of voluntary contributions the work of such private agencies which, from their own experience, they know to be essential to a well-balanced and integrated social program of a community.

Volunteers have not been asked to substitute in any of the functions considered the field of the professional worker, nor in the clerical service. The majority were not expected to give a definite block of time at regular hours.

This distinction between the two groups has helped to safeguard professional and clerical jobs even in emergency times, and has also allowed for a wider range of applicants for volunteer service. The recognized standing of the volunteer as a definite member of the public agency has made recruiting comparatively easy. Yet to attract the truly socially-minded person interested in human beings and anxious to serve them has called for continuous effort

*Mary E. Richmond, *Friendly Visiting*. American Unitarian Association, Department of Social and Public Service. Bulletin No. 7.

and study. Three main groups have stood out as most helpful in finding the right kind of volunteers:

Organized labor
Organized women
Private social agencies

Men and women from the working class interested in civic betterment and such social service as would meet the needs of the groups they understood best and represented, have contributed a great deal to change the thought and approach of social work through being volunteer members of neighborhood units. Incidentally, through their activities, the underlying idea of client participation has been worked out to a certain extent in a rather organic way. The integration of labor into the neighborhood committees has proved to be a very decided step forward in vitalizing the work.

Clubs and associations of business and professional women, as well as home-makers, have sent thousands of volunteers year after year into the public agencies for devoted and outstanding service. Very frequently they found this relationship to be of mutual benefit, since it helped to widen the scope of interest of the members and introduced many important issues into the associations' activities.

PRIVATE AGENCIES BENEFIT ALSO

Private social agencies were also benefitted by having their members participate in the public programs in large numbers all over the country. Many problems of local coöperation and of division of functions between public and private agencies were gradually solved by the very fact that volunteer workers were mingling in common experiences and close daily contacts. The constituencies of the private agencies frequently brought open minds, flexibility and freshness of approach into the public set-up while the public agency's task to meet the complexities of mass needs offered a challenge to revise traditional methods and functions of private agencies.

Beyond these immediate values for the sake of which the public agency may well cultivate the volunteer, many will be ready to accept a wider challenge. May we not visualize the public agency as a means of service not only to such clients as at the moment are in need, but to the members of the community at large? Is there not a very deep need for better human relations, more understanding of human problems, in all fields of public and private activity, in industry, in education, in legal action and in family relationships? May not generations of volunteers from all walks of life, of all ages, and in close contact with professional workers of experience and vision, grow into a tremendous instrument for the good of the community? May not the public social agency —also in its relation to the volunteer— strive to function as a part of government desiring actively to develop progressive leadership and coöperation among all citizens?

Looking back over various experimentation and experiences in integrating volunteer and professional work, it seems that public agencies should consider it a permanent need and part of their permanent function for three main reasons:

To achieve the highest standard of service, in a truly economical way

To organize continuous interpretation and safeguard community support

To help develop a feeling of community responsibility for every fellow-being, far beyond the contacts of organized social work.

Improving the Teaching Ability of the Nurse*

By RUTH GILBERT, R.N.

Mental Hygiene Supervisor, Visiting Nurse Association, Hartford, Conn.

THIS subject is a favorite with all of us—lone nurse or member of a large city organization. That so many of us are working to improve our teaching ability proves this not only to be a real need for the more successful carrying on of our family health work, but demonstrates it to be a conscious need. We are aware of wanting to do better in this respect. And yet it is sometimes surprising to find one's self vaguely thinking of the teaching ability of the nurse as a sort of *emanation* from her. Sometimes this ability emanates and sometimes it does not. We are always hoping that it will. In a way we feel that teaching ability is a little like inspiration—something beautiful to see when it does arrive, but very largely a gift of the gods.

When this teaching ability does not emanate freely, then we are apt to believe the time has arrived to *apply stimulation*. It is hard not to think of stimulation as a convenient something, immediately applicable, which will cause the nurse to leap along the right road as though suddenly she had been stung by a bee. Painful recollection brings to mind, however, that bee stings send most persons "up in the air" rather than animatedly along the road, and that the one stung has a tendency to sit down and nurse her wounds rather than to speed on her way. But if stimulation cannot be applied suddenly and directly, it can be broken down into some of its component parts, a number of which are found to have surprisingly familiar faces. Some of these parts deal with exceedingly practical matters. The nurse teaches with her whole personality. Therefore in planning to improve the teaching ability of the nurse, we have the whole nurse to consider. We might think first of the environment of the nurse as it affects her teaching ability and then consider the nurse herself.

THE ENVIRONMENT OF THE NURSE

The organization for which she works forms the immediate environment of the nurse. If she is to teach well, it must offer her a certain amount of security plus conditions under which she can work without unbearable strain of an avoidable kind. For instance, she must know well that her organization believes in her and stands ready to back her up. Her salary, vacation, sick leave must be equable. She needs sufficient desk space to work easily without having to exercise mutual forbearance with her neighbors. As important as any of these, she needs sufficient time at her desk before leaving for the morning's calls so that her work for the day can be carefully planned and so that she herself may be in a frame of mind which permits good teaching on her part. More than this, her environment must furnish stimulating working conditions—a job which is interesting or which has possibilities of being made so.

No doubt the environment of many field nurses is to a large degree determined by the supervisors who are attempting to aid her in her work. Because of this it would seem necessary, if the supervisor is to help in improving the teaching ability of the nurse, that she analyze as objectively as possible her relations with and expectation of the nurses whom she supervises. So much is written and said on supervision these days that it would seem most supervisors have a good intellectual grasp of the rôle the supervisor is to play if she is to be helpful. We draw from the teaching profession and from industry and we are working out our

*Presented at the N.O.P.H.N. Round Table for Educational Directors and Supervisors, Biennial Convention, Washington, D. C., April 24, 1934.

own contribution. But has the supervisor always analyzed her own emotional needs and how does she actually regard the nurse whom she supervises? Sometimes when we are able to be honest with ourselves we are alarmed to find a wide disparity between the way we feel and the way we have supposed we felt.

For instance, does the supervisor perhaps regard the field nurse as a child—*her* child—whom she must direct in everything and whom she must protect? Have not all of us heard a supervisor jokingly refer to the nurses under her direction as her "children"? Perhaps this strikes deeper than the supervisor is aware and is hindering the development of that group of nurses. In other words, it is hard for a "child" to develop teaching ability.

Perhaps the supervisor is a person who needs to feel she is superior to the field nurses with whom she works. It may be there are within her some deeply hidden feelings of inadequacy and inferiority which she dares not drag out into the open air. She keeps a wary eye on her nurses feeling indeed that they are inferior in understanding and presence—unpleasant as all this sounds—and not to be entrusted with certain community contacts. Again, in other words, if the nurse cannot feel reasonably sure of her own abilities, how can she develop into the kind of person who can be a good teacher?

Or—another possibility—is the field nurse just one of a group whose potentialities and individual differences have remained unanalyzed by her supervisor so that the nurse has not been helped in any signal fashion to make the contribution which is uniquely hers, and which as a human being she wants to make whether or not she is aware of this?

Increasingly often it is believed the supervisor regards the field nurse as a professional person, another worker, one who can accept responsibility and can grow. She may even outdistance her supervisor—a person from whom the supervisor can accept "showing up" on occasion.

With regard to the contribution which the environment may make to the teaching ability of the nurse, two other potentialities present themselves which we would all agree are important even though they are dealt with here so briefly. Staff educational programs if they are to prove sufficiently interesting to the nurse to become absorbed as teaching equipment must be at least in part initiated by her and must be participated in by her. Furthermore, as the second potentiality, an understanding of the policies of the organization and an opportunity to make suggestions regarding them make these policies a living reality—something to be incorporated in one's teachings rather than accepted as a set of rules.

Not only does the organization which employs her constitute a part of the nurse's environment but the district or community in which she works laps her about with possibilities for growth or discouragement. To emphasize one aspect only—an aspect which public health nursing organizations only lately have come to realize is subject to their analysis and control—the nurse's case load. Case load is understood to mean here, the number of families or individuals (one or the other according to the manner in which the nurse counts her cases) on whom she keeps a continuing record. If the nurse is to develop teaching ability or to have opportunity to use what teaching ability she already possesses, she must have the privilege of a controlled case load. This means an opportunity to limit *through the established policy of the organization* the number of families carried by the nurse to a number with which a capable nurse can do a good teaching job. Experiment plus local conditions must show us what this number shall be.* Through such control the nurse

*In an address on "Case Loads" before the Public Health Nursing and Board Members Sections of the Connecticut State Nurses' Association, at its 1934 annual meeting, Miss Marion Douglas, Director of the Visiting Nurse Association of Hartford, suggested one hundred families as a number to be tried out experimentally as a possible case load for a nurse carrying a generalized public health nursing program.

is enabled to know why she carries each individual and family so that her teaching plan and her progress or lack of progress by family and by total case load, may be understood and analyzed by her. Such a policy actually gives the public health nurse time to think! Far from detracting from her service to the whole community, a controlled case load makes the services of the nurse of infinitely more moment through her developed philosophy, sense of values and precision. These three should form a trustworthy basis for good teaching by the nurse.

THE NURSE HERSELF

In discussing environment we have in a sense been clearing away the underbrush so that the nurse may function, and we come now to a consideration of the nurse herself in conjunction with the problem of improving teaching ability. Here we might introduce directly the problem of motivation for we all recognize that any nurse must be activated by a living interest if she is to be a good teacher. Her interest must be of the type which sits up and takes nourishment.

How do we recognize this interest when we see it? Its signs and symptoms are apparent in the manner, bearing, voice and facial expression of the nurse. Furthermore, it actually must "take nourishment." In other words, does the nurse reach out after content? If she does, might this not be an assurance that the interest is real and not a mere expression of superficial vitality?

Motivation, like the supervisor's analysis of her relations with her field nurses, likes to appear in masquerade. It is a little upsetting sometimes to discover that what we had welcomed as an especially lively interest in the job is actually an overly strong personal drive whose effect may be on the whole destructive to both nurse and patient. It would seem possible to make the "diagnosis" by some of the following test questions. Has the nurse breadth of interest—on the job and off? Has she a satisfying lack of protectiveness and possessiveness of her job and patients or are the job and the patient in turn *her* children through whom she lives—to be considered as right or else shielded? Has the nurse an ability to profit by constructive criticism or, again, is the job so much herself that criticism becomes an unbearably personal matter? Has the nurse a marked need for personal recognition when a piece of work goes well? Happy the nurse who can honestly apply the test herself.

Given a living interest on the part of the nurse, how can one foster it—to return directly to the problem of improving the nurse's teaching ability? Some environmental factors already have been mentioned. Beyond these, the nurse needs an opportunity for conscious growth which carries with it as a by-product a growth in teaching ability. This leads us to consider the specific qualities in which the nurse shall seek to grow. Lee and Kenworthy in "Mental Hygiene and Social Work" familiar to so many of us, regard as not sufficiently exact for our purposes such descriptive terms as "tact, sympathy, good nature, understanding and diplomacy." Of the qualities discussed by them as essential for "one who works with people" at least three seem fundamental to the public health nurse who would improve her teaching ability:

Objectivity: "The capacity to deal with a situation or with another person without allowing one's judgments to become distorted by one's emotions."

Range: "A combination of creative imagination and mobility of knowledge which enables a worker to see as widely as possible into the possibilities of a situation" (Opposed to "getting in a rut").

Leadership: "That quality in human relationships which permits the exercise of personal influence over others without weakening their own initiative."

One cannot so grow in personality without growing in the understanding and philosophy which must be the basis and "spring-board" for all good teaching. The necessity for *conscious* growth on the part of the nurse already has been mentioned. Such personality traits and developing concepts as are described above grow only out of the daily experience of the nurse in her work and can

be made concrete and meaningful by the supervisor. We cannot merely teach the nurse to teach. Such ability must be "knitted into the structure of her being" through her own experience. The supervisor studies the conditions under which the nurse works, studies the nurse's records and observes her work. Nurse and supervisor evaluate the work done, relating it to the family plan; to what has been accomplished; to the growth of the nurse. In other words, a job analysis is done. Evaluation leads to revaluation. As the nurse grows, the supervisor's interpretation must keep pace. There can be nothing static about this process. Hours of conference time are necessary for nurse and supervisor to work this process through but the process is a timesaver, a nurse-saver and a patient-saver in the long run.

The above paragraph has been written from the point of view of a worker in an urban public health nursing organization where frequent contact of field nurse with supervisor is possible, but the principles developed seem as applicable to the worker in the small organization or to the "lone nurse." Probably it is the hope of the latter that she will be increasingly able to get supervisory help from her State supervising nurse, but at any rate, it would need to be true that the nurse who is at present working alone, with only such aid from National or State organizations as she herself takes the initiative in getting, is accustomed to accepting responsibility and facing hard facts and necessities. Perhaps some of the possibilities we have been discussing may help her in supervising herself.

Industrial Nursing for a Large Newspaper

By BLANCHE TOWNSEND, R.N.

Chicago Tribune, Illinois

TO describe the work of an industrial nurse employed by an organization which finances an Employes' Benefit Plan, is to describe the policy of that organization toward the individual employee. The Chicago Tribune adopted its first Benefit Plan December 1st, 1919, and revised it October 1st, 1924. The plan as it now stands includes:

Sickness and Accident Disability Benefits
Dental Service
Vacations
Death Benefits
Pension Plan
Wedding Gifts
The Medill Building and Loan Association
The Dearborn Mutual Benefit Association.

Any employee may belong to the Employees' Benefit Plan, the requirements being that he pass the physical and dental examinations and abide by the few, very generous rules. However, no one is barred from work because he cannot pass these examinations, or because he may not care, for some reason best known to himself, to join. The members of the Benefit Plan are then classified into groups as follows:

Class A—Includes employees who have been in the employ of the Tribune for ten years or more. In case of illness they are paid full salary for twenty-six weeks and half pay for another twenty-six weeks. If at the end of fifty-two weeks an employee is totally disabled and is under sixty years of age, he may make application for and receive the thousand dollars provided by the total disability clause of the blanket insurance policy held by the Tribune Company for the benefit of employees who have completed five years' continuous service.

Class B—Employees who have been in the employ of the Chicago Tribune from five to ten years may have thirteen weeks full pay and thirteen weeks half pay for illness if necessary.

Class C—Employees who have been in the employ of the Company one to five years are entitled to six weeks full pay and six weeks half pay.

Class D—Employees who have not completed a year of service. If there is need for help in this class it is investigated by the Medill Council (a committee composed of a representative from each department which meets to decide the policy of unusual questions in the administration of the Benefit Plan) and

handled at the Company's discretion, acting on the recommendation of the head of the department in which the person is employed.

The nurse is employed as an investigator. Her office hours are nine until twelve A. M. each working day and during the afternoon her time is devoted to making calls on sick or disabled employees. She is authorized to give first aid, and to collaborate with the Company physicians in the care of employees requiring medical and surgical assistance during the day, and to give professional advice to any employee concerning the physical welfare and health of himself or his dependents.

A FRIENDLY AMBASSADOR

In 1928 I relieved my predecessor for six months, and in talking over the work with one of the executives I was told: "You are the friendly ambassador from the Chicago Tribune to its individual employees. We cannot go, so we send you." When I returned, in 1931, I asked another executive what his conception of the nurse's work was, and he ended his remarks with this: "Anything that you can find to do that will make any Tribune employee happy—that is your job." We have a slogan in our office to the effect that the best medical care available is none too good for Tribune employees.

We have a dentist, who, from January first this year, to June first has worked 396 hours, taking care of 570 appointments. This dental work consists of examinations, prophylaxis, advice and more advice, and a certain amount of emergency service. Employees enrolling in the Employees' Benefit Plan after 1924 must come to the dentist once a year for five years, and must have the work prescribed by the dentist done by their own dentist in a reasonable length of time designated by the Tribune dentist.

Since (quoting from "The Trib", the house publication for Tribune employees) 43.2 percent of all Tribunites have been with the Company ten years or longer and 19.8 percent have been with the Tribune fifteen years or longer, it is necessary to convince a certain percentage of these people that regular dental and physical examinations aid in the promotion of good health.

Our industrial accidents are kept at a minimum by an efficient Insurance Department, which watches and checks any condition that may become hazardous.

Teaching preventive health measures to the individual members of this large industrial family is a major part of the day's work for the nurse.

During 1933 we had 557 employees on the Employees' Benefit Plan payroll, a total of 6,069 days on full pay, and 15 employees, a total of 1,062 days on half pay.

For the first five months of 1934 employees have been away on full pay 2,189 days and at half pay, 688 days or 105 employees off on full pay and 11 off on half pay. During the same period the nurse has had 1,330 office contacts, and she has made 497 visits to see employees in their homes or at the various hospitals.

During office consultations 56 have been referred to their private physicians and 53 contacts have been made with medical social agencies.

During the morning reports must be written of the calls made the previous afternoon, so that the department heads may know how to plan their work. These reports cover the diagnosis, physician's name and address, prognosis and possible date of return to work.

A very great many of our Tribune employees have carried double and triple responsibilities during these last few years, and so the bonus paid just before Christmas as a gift from the Company has been most gratefully received and does add to the general high morale. As I meet employees in every department I am impressed with the feeling the individual employee has about belonging to such an organization. The Tribune employee feels that since he works for the Chicago Tribune and the Chicago Tribune is so absolutely fair and square with him, he must play the game the same way. That there is a certain standard of conduct that he must maintain, particularly since he is certain that it is his department that puts the paper on the street.

EFFORT AGAINST TUBERCULOSIS

We are making a determined effort to see that no employee arrives at a state where he needs sanatorium care, by immediately sending anyone who is a contact case, or anyone who presents a suspected tuberculosis picture, for chest examination and observation. As a large number of our employees live in the suburbs, we are happy to be able to send them to the various Chicago Tuberculosis Institute Health Centers. In the first five months of this year there have been 56 chest examinations, 11 of which were made on contact cases, and 11 more examinations on definitely diagnosed cases.

FOLLOW-UP ON PENSIONERS

One piece of work that was pure joy was the calling on the pension cases in Chicago and suburbs. I was able to go into the homes of these employees who have served their time and found them comfortable and happy with the assurance that they need have no worry over finances in their old age. It was, indeed, a pleasant mission to go in a spirit of friendly interest and to tell them that they need not worry about their pensions, for they would not be docked or discontinued.

OTHER TYPICAL SERVICES

Going into the home of a Russian to persuade his wife to let him have his teeth examined as a preventive measure against future illness; advising a Lithuanian mother where she may have her brood of five weighed, measured, and examined at regular intervals; advising a Bohemian employee and his wife about a good location where they may live so that their only daughter, who has just finished grammar school may attend a Catholic high school and continue to live at home; helping an aged Irishman and his wife to be properly fitted with glasses; taking a foreign-speaking mother (the widow of a Tribune employee) to the Tribune law firm to receive a check for $1000.00 insurance, which the Tribune takes out for its employees at the end of five years' service, and on which the Tribune Company keeps up the payments, and taking her from the lawyer to the most reliable bank, and finding for her a bank employee who speaks her language so that she may have the procedure of banking her thousand dollars fully explained to her; giving special attention to the employee who lives alone in either a rooming house or hotel; calling a private duty nurse for the woman who does not want to go to the hospital, and is sick and alone in her apartment; helping this one reduce, under the supervision of a physician, and trying to persuade others that too slim a silhouette, what with work and social obligations, or possibly schoolwork carried on at night, is not the pathway to permanent health. There is no need to tell you that the days are full and satisfying.

MAGAZINES FOR THE SICK

The employees in the Auditing Department keep me supplied with magazines, so that no employee kept at home by illness may lack reading material. We have worked out a plan for a circulating library for our sick employees, which we hope to have in operation soon. Before each Christmas, books reviewed by our Literary Editor during the year, are given away to the employees and through the kindness of this same Literary Editor and our Librarian no employee is missed because he is at home, ill. We are supplied with enough "Tribs" each month, so that no sick employee misses an issue of the Tribune's magazine for its employees.

Public Health and Social Hygiene*

A Summary of Principles

By JOHN H. STOKES, M.D.

THE TWO PRINCIPLES OF PUBLIC HEALTH CONTROL

EVERY good citizen, not to say every nurse and social worker, owes a double duty in the prevention of disease: To assist where she may in ferreting out the source of infection, and to bring the source of infection to treatment and hold it there until danger of transmission, and of social as well as individual consequences from the disease is over. In comparison with these two practical measures, all that of which I shall subsequently speak will compare in speed of ground coverage as the tortoise with the hare. By a sufficiently intensive and complete application of the public health principles, we could extinguish one venereal disease, syphilis, within a generation, and make some as yet undreamed of headway against the others.

It is the duty of the public health nurse, then, to find the source of a recognized case of venereal infection, the contact from which it came, and those to whom it may have been passed on. Your rôle need not be that of an informant. Often you can be more useful as a persuasive force. For that reason you must know the modes of transmission of syphilitic and gonorrheal infections and the places and hours at which examination and treatment, public or private, can be obtained for infected persons in all stations of life. I take it that you know, too, that a mere awareness is not sufficient to produce results in this field. All doctors are aware, too often and of unfortunate necessity, merely aware of these facts. The day is coming, I hope, when a whole corps of social workers, trained to ferreting of this sort, will be at work in every state of the country, running down the sources and the contacts of venereally infected persons, and gently but determinedly bringing them to treatment. Persistence is the principal ingredient in the art of the epidemiologic ferret; many can recall the facts who first forgot and then lied, if they are approached through an appeal to fair play, consideration for others, and a genuine personal and friendly good will.

I take it that you know, too, the mechanism of follow-up in venereal disease control; how vital it is that patients pursue treatment until they have been rendered non-infectious and free from risk of relapse; and how seldom, indeed, it is possible to persuade them to meet our standards. In syphilis, thirty per cent is average, fifty per cent is good, and seventy per cent is wonderful follow-up efficiency on ordinary clinic material. You who meet the patient in his home have the advantage of the clinic worker. Your *rapport* is often closer. The clinic social service chief must specialize in mass aggregates, use sweeping methods to influence the largest number, on the run so to speak. You meet the individual case, you convert the doubting, the hesitant, the weak or irresponsible, the uncomprehending, on the ground.

I cannot speak on gonorrheal treatment standards, but I can say for infectious syphilis, by way of new knowledge, that an arsphenamine is a necessity—the only agent that really controls infectiousness; that nine to fifteen injections is a minimum, twenty-five to thirty injections a satisfactory standard to which to persuade your patients. Preg-

*Excerpts from a paper presented by Dr. Stokes to the nursing staff of the Association for Improving the Condition of the Poor, New York City. Dr. Stokes is Professor of Dermatology and Syphilology in the School of Medicine, University of Pennsylvania, and head of the Clinic of Cutaneous Medicine and Syphilology of the University Hospital.

nant women with syphilis should receive arsphenamine. Ten injections given in proper distribution will yield better than ninety per cent healthy children. Fight the conservatism of general practitioners and obstetricians who do not take Wassermanns on pregnant women. There is a rich harvest of preventive medicine here that you can help to gather. Patients leave treatment because they have been hurt, had reactions; because they cannot afford treatment; because they cannot meet the hours. Work, therefore, for night clinics. And finally, if you want to start a little useful research of your own, find a collection of extragenital chancres — "tonsillitis" and "diphtheria" chancres, finger chancres, nipple chancres—the chancres that nobody suspects, not even doctors and nurses when they occur on their own persons. There are more of them than anyone realizes, in babies, in children, in adults. A slow-healing, not very angry but persistent sore—often interpreted as a cold sore on the lip, or a "felon" on the finger—with an enlarged, often a very large lymphnode in its immediate neighborhood.

SOME PRINCIPLES OF SEX EDUCATION

Sex education is the turtle of the venereal disease control race. In its slow, hesitant, groping course, it offers at times a discouraging contrast to the easy lope of the assured anti-infection rabbit of the public health program. But in the end, it may well go farther, for through its efforts alone can we hope to cross a goal far in the future; the goal of a happy, effective, adjusted sex life, of which the venereal disease problem is but a milestone in the course to be run. Sex education, in its turn is only a phase of the problem, as you well realize who see at first hand, as many do not, the problems of the economic status of marriage, of birth control and voluntary parenthood, of child hygiene and adolescent delinquency, of prostitution and law enforcement.

Consider first what is requisite in yourselves if you are to be of use to any one in a sex problem. First, you must be able to impersonalize; to shed yourself of the herd squeamishness and the accumulated "not nice" traditions we lump with "taboo." You must not proceed to the other extreme, however, and develop an overgrown eye, a microphone ear, and a magnavox delivery for sex phenomena. Side by side with a serenity, you must cultivate a healthy belief in the normality, the validity of the whole business. You may even champion the sex side of life as a misunderstood, undeveloped, or blunderingly mishandled phase of being; but be cautious about calling it repressed, for the word is "out of order" just now. Believe heartily, then, in the rights of sex to expression, but offer wisdom as to the forms of expression. Have no shame and no morbid interest. View sex phenomena, not as good or as evil, but as life. They may sometimes disgust, but disgust projects them outward at least, and shame tends to drive them back. Be sparing even of disgust, for little, unless it be the perversions, merits it. And having achieved the dispassionate detachment, though not remoteness of the mental attitude, always preserve the mental angle of the observer. It is not necessary to have experienced all, to know all. In fact, experience is a crude teacher, too often fit chiefly as a bludgeon for the heads of fools. Be then an observer, a student. From what you observe and study, quite as much as from what you experience, you may teach. Some persons are constitutionally unable to teach in this field. You must, therefore, using the criteria I have given you, ask yourself frankly if you can achieve the mental attitude of the serene observer, and if you can do so, you may, in time, venture to teach with humility and frankness.

INDIRECT, EARLY TEACHING

The teaching of sex culture rests on several general principles. In the first place, it involves a laying out or a bringing to light of the subject between the two extremes of an overgrown curiosity and a shamefaced repression. So personal is the sex life that indirection becomes at times more important than direction in its teaching. More can often be learned from the general principles of wise and extended living than

from any single isolated group of sex facts as such. The sex life too is subject to a tidal ebb and flow, and the period of greatest educability for many of its most personal aspects is just precisely the impersonally colored or neutral period of preadolescent life. During this time, the self-consciousness that too often makes morbid personal issues out of common facts, is still unborn, and like a planting of seed, the right teaching may result in the garden of a well-ordered life in place of a patch of lush weeds. Not to be too metaphorical, then, much of the best sex influence is indirect, the best teaching incidental to literature and the arts, quite as much as biology and anatomy and physiology. And the period of ideal receptivity for the fundamentals is childhood.

The next principle is, that what makes for right living makes for the adjusted sex life. One may perform the purpose for which nature created, so to speak, a reproductive function without character and principle, but the result is almost certain to be disastrous. The building of sound character then is the fundamental concern of the social hygienist, for without it long range methods of adjusting the sex life, and thus incidentally preventing venereal disease, have not a leg to stand on. After all, as I have many times said, a sound sex life requires little more than the principles of the square deal: self-control; a sense of fair play and the ability to sift fact from buncombe.

Sex conduct and culture are a part of life. Whatever makes for better general life adjustment, plays for better, healthier sex adjustment. Marriage, the conventional culmination of sexual development in man, is a vocation than which none has more power to make or to undo. It is, moreover, a career, and its product, the family, is the biological unit of society. If sex can be kept, so to speak, within the family, venereal disease is almost automatically excluded, for the overwhelming source of infection is the extramarital sexual experience. The family is therefore a prime concern of you who wish to help forward the cause of sex culture and disease control. While there may come a day when marriage for companionship will be differentiated from marriage for procreation, it will always be true that whatever tends to keep one man and one woman together solely unto each other, will work against venereal disease dissemination.

Advice from *trustworthy sources* is a chief need in the marriage field, and harder to get, and more sought when once made disinterestedly available, than most of us have any idea. The subject is too large to deal with here; but I can commend you a book (Wile and Winn, "Marriage in the Modern Manner," The Century Company), which will give you the essentials; and then tell you that most advice, judged by what one sees of the problem afterwards, is not specific enough. The writings of Dr. Marie Stopes opened this field to English readers, and the works of some of her successors, too, now at last available in this country, are useful for those who are fitted to teach and advise in this field (as for example, Isabel Hutton's "The Sex Technic in Marriage," Emerson Books, Inc.). Before you assume the responsibility for giving advice, read Karl deSchweinitz's really immortal description of the mental attitude of the confessor, in his book on "The Art of Helping People Out of Trouble." Sublimation is the one safe device, sound for both self and social order, which any of you, having learned to use it on yourselves, can apply to your patients. Teaching the alternative outlet is sound sex culture, workable in clubs, gymnasiums, everywhere—even in that last round-up, the public school.

THE ROLE OF THE FAMILY IN SEX CULTURE

You will understand, will you not, though I do not insistently repeat it, that I am trying to impress you with the ways and means of keeping venereal disease out of the sex life, by perfecting its biologic and psychologic impregnability through a successful family life. If one man and one woman can be kept sole through childhood and youth, and when reasonably early joined, can be kept joined solely to each other through life venereal disease has no field for its

activities, comparatively speaking; for venereal infection invades humanity through ignorance, ungoverned or thwarted passion, and the extra and anti-marital infidelities and disaffections. Even an approach to the ideal in family life will materially reduce the incidence of infection. Not only is the family a disease excluding unit, but it is the best perpetuator of itself, the strongest inspiration to a high standard of sex culture, that exists. It is with profound concern that a venereologist must observe the loosening of family bonds that seems a part of the psychology of the day. The modern sex novel and its counterparts in life leave two vital problems unconsidered. Their plots will work if the contraceptive works, and if the principals do not transmit a venereal disease. If they do, the highest sounding ultramodern viewpoint finds itself instanter in the ditch.

Do everything you can, then, to conserve the solidarity of the family—a truism to be sure, but too lightly thought of these days. It is too easy these days, with all our institutional methods of dealing with the child, to forget that the family in which he grows up is without substitutes and without rivals as an object lesson in sex culture. Sometimes directly, sometimes, but happily less often by opposites, it teaches him as only example rather than precept can, what it means to see a man and woman who have love between them, weather the storms and batterings of this life.

THE ROLE OF THE PARENT

It is a little difficult for me to put myself in your shoes as you go among your patients, meeting many lives devoid of the privacies, the decencies which to us are the mere commonplaces of sex life—the door to the watercloset, the privacy of a room for dressing and undressing, the bed shared with one's own sex or no one. In such an atmosphere initiation by experience must stride far ahead of even the earliest and most advanced instruction. But I can offer a few comments for what you may be able to make of them.

The communication of sex information is logically the duty of the father and mother and more often the latter. Where there is any possibility at all of their meeting the demand on them, they must be prepared for the undertaking at the points where they are invariably weakest; their self-conscious shamefacedness; their ignorance of cultural background and biological relations; their limited and stammering vocabularies. The obvious short-cut in dealing with such a situation is to supply a book to be read to children, behind which the parent can hide his face, while the printed page supplies the ordered perspective he cannot bring, and the words he does not have, to meet the situation. The most remarkable book of this kind which I have seen, quite unequalled in the perfection of its diction, the artistry of its format and the simplicity, directness and beauty of its appeal, is Karl deSchweinitz's "Growing Up" (The Macmillan Co.). I commend it to you as something to carry in your bags. It makes, with surpassing ease, the passage between Scylla and Charybdis in which parentage usually meets disaster—the transition from biologizing, to the physiology of man. The pictures are remarkable, and in themselves capable of conveying to the youngest child, the spirit without which the flesh is nothing.

As I have said in stressing the family life as example and inspiration, the duty of the parent is not merely that of communicating information. His attitude can determine the one most essential element in childhood sex education—the proper mixture of reticence and frankness—reticence to the outside world, frankness within the family itself. No inclination to seek or experiment with outside sources of information or experience, and no hesitation in putting to the parent any question that may arise or reporting anything observed, is a most difficult ideal to attain. It may be taken almost as axiomatic, that casual outside sources are contaminated, and that inside sources, even though inadequate, are better. Knowledge of sex should come through the family first of all, and in the effort to bring this about, parents should be coached on what to expect, and how to meet it.

They must be disabused of the idea that nothing will be demanded of them until puberty; for the first five to seven years of a child's life is much more critical than the second. An exclamation of horror at any stage may wreck the *rapport* that should be established—a single evasion or untruth from the parent lead to everlasting distrust, and to ultimate and dogged silence.

THE TEACHING OF THE CHILD

I question very much if it is possible to begin too early. By seven years it is often too late. Officially one is supposed to let the child take the lead with questions, of which "Mother, where did I come from?" and "Mother, what do little girls (or boys) look like?" represent the two phases. From the first, refuge may be taken in generalities to some extent. The second backs you squarely up against the realities of human reproductive anatomy, if not physiology. I believe it is easier—I know it was easier for me—to take the situation by the forelock, and to set the stage for each group of question as it is about due to appear.

In teaching sex to children, the capitalizing of infancy is quite permissible and should be skillfully done. The arrival of the new baby is an opportunity of the first order, and little brothers and sisters should be drawn into the problem of its coming, its life and care with a fine and tender enthusiasm. You who have the duty of caring for the newborn will see for yourselves, I am sure, the ways in which you can turn such situations to account.

THE SEX GUIDANCE OF THE ADOLESCENT

The work of steering the adolescent through the storm and stress period is a field for expertness. I do not pretend to it myself. Viewing it in the retrospective light of consequences, I think of it, first, as a time for whose peaceful passing most of the work has been done years before. The free exchange of confidence has been prepared for in the first decade. The intense self-consciousness has been controlled by the objectifying approach. Substitutions and sublimations have been prepared in the field of sports and energy-dispensing activities. Idealism has been fed by the parental example of a deep affection, and the sense of belonging that every child should have. A skilled observer may detect, but be cautious in attacking without expert guidance, the projecting angles of a father-son competition, which Franz Alexander rated as the basic fact in the man's personal life; or he may nip in time, again with wise help, the mother-son and father-daughter complexes that leave such a trail of disaster in marital life. No child should enter adolescence without the elementary facts of human reproductive life quite clear in his mind; and again, I believe, with the principle of "hands off" the sexual parts reiterated as a form of suggestion, through the earliest years. Then comes the difficult period for the parent, when the decision to hold back, to keep aloof, must be made against the inclination to interfere. For this time, which every parent recognizes and dreads, there is no recourse except an unblemished record in the earlier years. The work, as I cannot too often reiterate, is done before puberty, and parental meddling after it, too often breeds harm instead of good.

The question as to when the knowledge of venereal disease shall be given is one that I as a venereologist find it hard to answer. To make it a part of mere "fear-protection" is inherently repugnant, and its value is largely lost in the counsels of the gutter, the pool room, the corner drug store and the college "bull session." Yet by eighteen, information may be essential. Fathers will have to seize the chance to talk to boys, and mothers to girls, as the moment and the occasion offer. What exactly should the adolescent in his late teens be told? First, that there are infections, syphilis and gonorrhea, carried by persons who accept or indulge in casual sexual contacts, including kissing, necking, and petting as well as actual intercourse; that there are no reliable external signs to warn of the danger within; that there are no "sure things" and the very person who thinks himself safest may be the surest caught; and that every person, drunk or sober,

who exposes himself should within the hour if possible seek reliable medical advice. The symptoms at onset, the consequences to personal health, and above all to husband, wife, or child, should be impressed; and warning against self-treatment or drug store prescribing emphatically given. There is no need to horrify. The quietly told facts are enough.

The moving picture desperately needs reform. If you need a cause to champion, here is one worthy of your support. Join in campaigns against block-booking systems which contaminate with as dreary and sordid a commercialization of sex as could well be imagined even the thin rill of worthwhile material now trickling through our theaters. The point of attack may be your Board of Censors, which calls a serious and enlightened effort at public education like "Damaged Lives"* obscene, and passes without question the current picturizations of the selected loose moments and polygamous activities of historical personages. You may join a national organization for clean-up, or stimulate a local mothers' club boycott. Generally speaking it is the producer who needs to be collared; and he, in far-off Hollywood, can be brought to book only through his box-office contact with the public.

The collective teaching of adolescents on sex matters, by lectures, in clubs and camps, in schools and semi-religious gatherings was for a time thought to be the chief available mechanism for dealing with sex education. It seems to be losing popularity, quite understandably I think because speakers fitted to deal with audiences on the most intimately personal subjects in life are so few and far between; because teaching of this sort invariably comes too late to make any fundamental difference in the basic sex morale of the audience; and because of the difficulty of putting atmosphere of the right sort into such occasions. Very much more promising should be the cinema attack on the problem of mass education—far more graphic, closer to life while at the same time more impersonal, and susceptible of experimental trimming and alteration as the reaction of the audience is watched. Any one can give a smut lecture—only the gifted can lead a crusade.

Wherever possible, therefore, try to break up sex teaching into small units that can gather around the knee, so to speak, and know where a competent child-guidance expert can be found to assist expertly in mental adjustments. It is astonishing how even the medical commonplaces of an acne may carry below the surface a problem in sex adjustment vital to the future of the individual. And where teaching must be *en bloc*, impersonalize it by bringing in more art, more literature, more biology; more indirection, in other words. To get right down to the human fundamentals in the soundest way, speaker and spoken to must be almost, if not quite, eye to eye.

WHAT OF THE FUTURE OF SEX EDUCATION

I find not unwelcome the steadily growing frankness, the elimination of buncombe from discussion and comprehension of the sex life. I do not fear even the experimental mood of youth today, the freer exposure, the freer sex play, the disposition to try it out, as much perhaps as some. We are merely in reaction. To bring reaction back into line, think for the future in these terms. Begin on the material early—in a planned way—from infancy. Work harder on the family and the home, less on the public gathering and the school. The finest that sex life can offer, at least as I see it, is knit up with the lifelong allegiance of husband and wife. Next to it stands the bond of mother and child. In our rush for the broadening effects of socialization, we too easily lose sight of this primitive unity. Blood is indeed thicker than water. Therefore expend education on the family. Try to develop the physical surroundings that encourage the children to come home after school, the father to

*An educational film produced under the auspices of the American Social Hygiene Association. If you have not seen it, try to do so.—*The Editors.*

return to it from work, the mother to put her pride and effort on it.

Sex and play are inextricably bound up with one another. This suggests among other things that the future should give some thought to a revival of those elements in play which teach sex ethics and sex life through the skillful indirection of toys and games. For example, dolls and doll houses kept centuries of women home-minded. As they vanish in the current athleticism of the drill and sports age, something useful may go with them. I venture it that in the corner of a city playground, even a miniature house not too officiously made a part of the lives of younger children, and managed with sufficient detachment by a playground director less intent on regimenting and more on individually developing his future citizenry, would be a fascinating research center for social hygiene.

And when it comes to marriage, I would have, for the future, plenty of competent advice. Institutes of Family Relations, to quote the present too high sounding name, are just beginning in several of our large cities. They should cover a field not touched by schools of domestic science in providing sound counsel and planned instruction in the psychological and medical problems of young engaged people, newlyweds and older couples in midchannel. How long shall we leave to the palmist, the soothsayer and, though not always in the same breath, the columnist, the lion's share of the guidance in these matters?

How shall we put the career enthusiasm into marriage; how lead those entering it to think less of its comparatively shallow possibilities as a pleasure mill, and more of it as a constructive expression of the full, the worthily lived life? For such questions as these, the sadly needed education for marriage must and will attempt to find and popularize the answers.

I have, as I finish, the feeling that I have offered nothing but a revival of old stuff, an outworn conservatism, inapplicable in today's conditions. The out-moded family of all things—even a hint at the consolations of religion! I ought to be talking companionate life in a kitchenette apartment, the automobile-made liaison and informal sex union. If I do not, it is not because, believe me, I do not sense the ubiquity of these things at the moment, but because I deeply feel that the values I have pointed out are nearer the foundation, broader, more solid than some of these later products of a perhaps overdone mechanical civilization. I give you as the best I have seen life able to accomplish in the field of sex, the fine human family—theater and scene of the most worthwhile of human emotions, the most characterful of human accomplishments. I believe you will make no mistake in trying still to hew to that line, overridden though it is, I hope only momentarily, by today's hard-driven expedients.

"Where there is full coöperation, a sort of partnership between voluntary workers and local authorities in a public service, then I have noticed that the results are almost always eminently satisfactory. The local authority gives that stability and that continuity which is so hard to secure for voluntary effort, and, on the other hand, the voluntary worker supplies that enthusiasm and that readiness to look beyond the rules into individual differences of character and conditions, which comes so easily when work is done for the love of the work and not merely because it is one's occupation in life. I question if in any field of social work this coöperation between voluntary and municipal workers has been more conspicuous than in maternity and child welfare."

—Presidential Address by the Rt. Hon. Neville Chamberlain, M.P., Chancellor of the Exchequer, National Conference on Maternity and Child Welfare, July 3d to 5th, 1934, Birmingham, England. *Mother and Child*, August, 1934.

Function of the Public Health Nurse

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IN the past twenty-five years there has been a slow but steady alteration in the approach to various social problems and the consensus of opinion is that this change has been progressively constructive. Progress implies a gradual development and a change in the various aspects of society which will bring about a greater satisfaction to the individuals and a higher level of social relationships.

In all of the provinces of human relations the importance of the personality is being felt. In medicine, the disease alone is not treated any longer but physicians are more and more treating the individual who has a particular disease. In dealing with the social and legal offenders, however slowly the change of attitude is, jurists, lawyers and all of the police officers who touch the offender, are seeing the necessity of dealing with the human being instead of merely punishing him for some specific type of anti-social behavior. This tendency of appreciating that the personalities of its members is, after all, the important thing in any group is largely due to the advance that psychiatry has made during these past years. The entire mental hygiene movement is based upon the findings that the study of mankind has made, which are that the make-up and degree of development of man determines what various social structures and organizations any particular era will have. Therefore, all provinces of our civilization are feeling this change of attitude and are beginning to see the fallacy of dealing with mankind's reactions apart from the organism which was responsible for the act. The function, therefore, of the workers in these various social fields has, of necessity, had to change and in no department of our modern health movement have we seen it any more apparent than in that of public health, which includes the function of the public health nurse.

For the public health nurse to perform her function with the best results, it is important that she have what is termed a well integrated personality and that she view her work with the approach for which the mental hygiene movement has been largely responsible. The sincere and capable public health nurse knows fairly definitely what she wants the various members of the community to do in order to protect themselves from the various maladies that might readily befall them, but the difficulty of her job is to get the community to carry out her ideas and in that sense to coöperate with her to the fullest. It is well to consider then why the failure in coöperation.

WHY DOES COÖPERATION FAIL?

In our daily contacts with people we see how much the acquiring of knowledge, which is termed learning, is dependent upon the emotional attitude toward the subject to be learned as well as upon the intelligence capacity to grasp the subject. There is many an intellectual potentiality not allowed to develop to its full capacity because of an emotional unwillingness or an inability in desire to know about the subject. For a person to find out about a problem and to acquire knowledge in any realm, the desire to learn is essential. Following this, action is taken by learning from books, teachers, or advisors. However, if a person is ignorant regarding a certain subject and does not see the necessity for learning it, is not intellectually able to grasp it or perhaps is somewhat afraid of what the knowledge would give him, then it is impossible to teach that person that subject. He must want to know before he can start the machine of learning. This is

no more apparent than in health matters. People, particularly the fearful, uneducated type, are made more fearful by the unknown and they have more psychic peace in their limited sphere of knowledge and ignorance than they have when they realize their lack of knowledge which necessitates their learning about something of which they are afraid.

CONFIDENCE FIRST

The old adage—what one does not know does not hurt him—is exemplified when a public health nurse tries to approach an ignorant mother about the problem of giving toxoid to the children. This is the one thing that the nurse must always bear in mind: that it disturbs the mental equilibrium of a fearful mother when something that is entirely foreign to her is offered. If she trusts the nurse and feels that the nurse is sound in her judgment then the woman is immediately thrown into a conflict between her belief in the nurse and yet her fear of the unknown, which is what might happen to the child if it is subjected to a new experience. It is essential, therefore, that the first requisite for helping these mothers is that the nurse have her contact with them strong enough so that they will be willing to carry out the nurse's suggestion with complete confidence in her advice without their becoming on the defensive to the nurse. This contact is best obtained when the nurse's personality is such that she can identify to such an extent with the person to whom she is giving advice that she can see the person's point of view. In other words, that she be able to get "under the skin" of the person and to picture herself in the same situation and emotional state as the person. She should not do this by talking about her own problems or what she did but she can attain her end by not placing emphasis upon the thing which she wishes to accomplish and by developing her contact in the commonplace, simple relations of daily life. To be specific, if a nurse wishes a mother's consent to having her child's tonsils removed, the question of the tonsillectomy had better not be mentioned if the woman is what is termed not wholly cooperative. If the nurse approaches the woman with a sincere compliment about how she keeps the house or what an excellent cook she is or how well the children are doing in school, or on any matter in which a warranted compliment can be given, then the woman will soon appreciate that the nurse is not there to impose her ideas and herself upon her, but is there as a medium through which she can obtain health care for herself and family.

Need it be mentioned that the public health nurse particularly should have handled her own personal prejudices satisfactorily enough so that she will not be put on the defensive by a client's disagreement with her ideas? A nurse who has prejudices regarding creed, color, or personality make-ups will certainly fail in her contact with clients or else her sphere of activity will have to be limited to a group who will not arouse her prejudices as much as another group might. For example, if a nurse has an antagonism to or hatred of a Chinaman, it is obvious that she should not be in a Chinese community, or, if she feels that there is only one church, one political party, one race or nationality that has any value, such a prejudice will only greatly curtail her energy output. The public health nurse has to be so well integrated and her self-confidence sufficiently developed that she will not have to be on the defensive for what she thinks is correct in the problems of health.

SATISFYING THE EMOTIONAL NEEDS

Having identified with the person to such a degree that she can grasp the person's defense reactions in opposing the nurse's opinion, then the nurse is able to understand the emotional need of the client. It is important that diseased tonsils be removed and inoculation against various communicable diseases is essential if we are to control these diseases, but if a parent's emotional need is financial security, fairly satisfying work, or a healthy marital relationship, the nurse cannot satisfy that need by

the removal of the children's tonsils nor their vaccination against smallpox. It is quite true that the nurse cannot give the financial security nor settle the marital problems nor offer a suitable job but her understanding of the person's wants and striving will make her much more able to show the parent the advisability of carrying out certain health procedures.

Another thing to bear in mind in the nursing field is that there is no finality in the settling of life's problems. Particularly is this true in medicine. If the things we know today were the last word then no future progress would be possible. All research, all study, and all scientific achievement are based upon the fact that we strive to learn more because we know that there is never a final answer to any problem in life. If a nurse feels that a member of the community will not abide by certain health measures and so incurs the nurse's disapproval, in such an instance all that the nurse succeeds in doing is to air her own narrowness of vision and limited outlook. If there is a law in a certain community that a child must be vaccinated before entering school, then all the nurse has to do is to state to the parent that the law is thus and so and that she believes in the law but is not responsible for its existence, that its validity was based upon the fact that vaccination prevented smallpox and that the eradication of the disease has come about by this prophylactic method. The woman then will have to make the decision whether she is to oppose the law or to abide by it, but her antagonism will not be toward the nurse.

THE NURSE HAS NOT THE FINAL, ONLY RIGHT ANSWER

No human being is justified in feeling that he or she has the final answer to life's problems whether they be regarding health matters or other questions arising in our society. The courageous and sincere person states his point of view and lets it be known how he regards the problem, but to impose it on another person by brute force or defensive coercion is not the means to achieve the end desired, namely, of convincing the other person that his method of procedure is faulty. The nurse, like all physicians, must be willing to listen and in that way to learn the client's objections in carrying out certain health measures. It will be found that the client has an emotional blind spot to the nurse's suggestions because of fear of the unknown or because it will necessitate another adjustment. In order to instruct people in public health their fear must be dealt with and the advantage of a new adjustment must be shown them.

In dealing with the child health problems of the present day, a suitable diet is stressed but this does not imply that there is a right or wrong diet for children in the narrow sense of the term. If the nurse goes into a home feeling that a mother is uncoöperative because she happens to give a child coffee in the morning, the difficulty is with the nurse's point of view and not solely with the mother's diet. Rigidity and lack of give in life is one of the reasons why so many personalities fail. To be sure, a growing child should not be given coffee when it rules out the drinking of milk and the eating of suitable food, but we know that many a child is well nourished and grows into normal physical stature and has had a certain amount of coffee for breakfast all of his life. There is no one single thing in a child's diet that is going to assure him normal physical development or prevent his growth. Therefore, if a nurse walks in when a family is eating and sees the child take something that is not prescribed in a child's diet, she is to view the question from the angle of not what one or two things is he eating that it would be best for him not to eat, but what are the suitable things that he is taking. If she has this point of view she cannot but show her sincerity in approving of the child's diet and the family will then appreciate that she is not there to prohibit but to view the question objectively. In a short while a member of the family will probably ask her about the advisability of altering the child's diet and then is the time that

they are ready for help and she will be prepared to give them sound advice.

TEACHERS NOT PREACHERS

The public health nurse not only has to deal with people in their homes but may spend a part of her working day in the schools checking upon the physical conditions and habit training in health matters of the school population. For this reason she not only has to have contact with the parents of the children, but she has to deal directly with the teachers and school authorities. As we all know, next to the home the school is the most important place in our social structure where children can learn the values of life and their relation to their fellowmen. The schools are no longer concerned solely with the three R's but, as has been mentioned previously, are directing their attention to the children to whom they are trying to teach the three R's and for this reason the health of the child has become a very important part of the school curriculum. The nurse must realize that the teacher has not had nurses' training and therefore cannot see the nurse's point of view. The nurse, on the other hand, has not had the teacher's training but it is her function to utilize the same procedure that has been outlined in dealing with the families whom she visits. To become impatient with the teacher or the school authorities because they cannot see the importance of certain health measures as keenly as the nurse sees them is only an admission on the nurse's part that she is as limited in her outlook as the teacher. If the nurse's attitude is such that the school feels it can turn to her for assistance in its health problems, then the nurse will have efficiently performed her function.

Part of the failure of our educational system has been due to the fact that our so-called educators have been "preachers" instead of teachers and for the public health nurse to assume the same rôle will meet with the same amount of failure. Education in any field, whether it be public health or greater social outlook, comes gradually but progressively and it cannot be attained by sudden and violent revolutionary changes. Many a public health nurse becomes discouraged because she cannot get the results that she wishes in the space of time that she has allotted to herself. She must bear in mind that she is neither omnipotent nor omniscient and must base the worth of her work not upon her failures or her successes but a combination of them both. In such a large educational project as public health, it is impossible to measure the good that is done by constant and understanding work with the members of a community. They may not accept the idea today but if they feel that they are free to make their choice, and it is a valid suggestion in the large majority of instances, the idea will slowly be incorporated in the community. Quick, violent changes are, as a rule, not sound and lasting and if a nurse goes into a new territory she cannot expect results immediately.

NOT DEPENDENCE

A few words should be said about the danger of too complete coöperation on the part of families with whom the nurse is working. The thing to be on one's guard against is the developing of a too great dependence on the nurse on the part of the client. For this reason the nurse's attitude to the client must always be impersonal without being patronizing; objective, yet subjective enough to understand the client's needs. A stronger emotional relationship cannot be had either in the positive or negative way without the work suffering. If a nurse becomes the mother symbol to a client, the chances are that the client's coöperation will turn into disappointment and perhaps hatred when the nurse is removed from the territory or if the nurse refuses to carry out the client's request at some future time. To be sure, the nurse is the symbol for good health, which includes the mental aspect as well as the physical, but this does not mean that any members of the community should symbolize the nurse as the one who will help them settle life's problems and upon whom they can lean for security.

To increase a person's dependency in facing reality is not what any personality should do to another. This fact is mentioned because social workers are clearly appreciating that some of their failures have been due to their misinterpreting dependency for coöperation, and because of the public health nurse's unique position in the community with the various families who need her help. She should bear in mind that her emotional reaction to her clients is fully as important as her knowledge of public health methods. She has an important position in the community and her satisfaction in her work and value to the community, as with all workers in public positions, are just as contingent upon a healthy mental make-up and attitude to life as they are on what technical training and experience she has had.

The Use of Records in Making A Visit More Productive*

By MARIAN G. RANDALL, R.N.
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THE public health nurse can use records to advantage *before* making a home visit, *during* the visit, and *after* the visit.

USE OF THE RECORD BEFORE MAKING THE VISIT

Let us pick up an actual record of an infant who has had one home visit from a health department nurse. The first time we go to a home for any type of visit, there is much that can be observed without asking direct questions; but there are several questions we are obliged to ask. There is no point in repeating these questions the next time; in fact there is a decided disadvantage in doing so. We may visit several different homes in the course of the day, but the particular mother does not think of that. The discussion about her baby was important to her and she expects us to remember it as well as she does. Aside from that, why waste time repeating questions, when we have the information recorded, presumably, and when there are many other points we wish to cover to make the most complete and satisfactory health supervision visit possible?

Let us look at this record of the Lewis baby before going to the home, to refresh our memories regarding the previous visit and to plan for the content of the current visit.

The *name* is not complete. We recall that Mrs. Lewis had not decided on the baby's name when we were there. We must remember to take along a supplementary name slip for the father to send to the registrar and explain the importance of complete registration. We note the birth has been registered.

Reported by neighbor, Mrs. Brown, who is a member of the Mother's Club. We may suggest that Mrs. Lewis talk with Mrs. Brown about the club.

Telephone. We did not inquire about that. We find the name is listed in the telephone book. It might be a good plan to call up and ask if Mrs. Lewis will be at home; it is quite a distance and we are trying to reduce our "not home" visits. This gives us another idea. Perhaps Mrs. Lewis is the type of mother who would telephone to us from time to time, and unless there is an emergency situation, frequent visits would not be necessary and we could devote that time to another case. We plan to discuss this with Mrs. Lewis.

For homes in which there are no telephones, postal cards can be used to advantage. A report from the mother that certain advice has been carried out and conditions are satisfactory allows

*Presented at the N.O.P.H.N. Round Table of Staff and Rural Nurses, Biennial Convention, Washington, D. C., April 24, 1934.

us to keep track of the case and may save our time for a more serious problem.

Physician. We did not write that down either. It is probably Dr. Black, but we had better ask again to make sure.

Date of birth—February. But what day? We remember now, there was an interruption when we were filling in that record and we did not get back to that item. Perhaps it won't matter—February to March to April—that's two months. But if it was the first part of February, that is nearly three months and it is time to inquire about additions to the diet and suggest seeking the physician's advice about this. We need that date—but of course we can look up the birth certificate; it won't take long. We find that it was February 26 and note at the same time that Dr. Black had charge of the case at delivery, which we fill in on the record in place of the check. At the same time we note from the birth certificate that this is the second baby, a point which had not been recorded on the record and also a point which reminds us to include the problems of the other child in the health educational visit. We realize that we asked all these questions but did not record all of the answers and we certainly cannot remember such things as dates. If recorded, it would have saved time looking the items up elsewhere. There is an advantage in knowing these things before making a return visit, so we make the effort to find out from some other source.

Coded material: We note that sleep, fresh air, and interval of feeding seemed unsatisfactory and plan to inquire especially about these habits.

Services rendered and comments. The most significant comment here is about the baby's crying. We were concerned about the child being undernourished and remember that we suggested consulting the physician if regular feeding and more attention to the mother's diet did not bring about a gain in the infant's weight and less crying. We happen to remember these things as public health nurses often do remember some details of cases, but we cannot or should not rely on memory entirely, especially when a word or two would make a record of these things. And, needless to say, another nurse taking our place would not know them if they were not recorded.

We are planning to talk with Dr. Black about another case, and as we look over this Lewis record we decide it might be a good plan to ask him about this baby also. We telephone the doctor and find that he has seen the baby, has suggested a special diet for the mother and also a formula to use in addition to the breast feeding. (We write these orders on the record.) He asks us to report to him how his advice is being carried out, and we start off for that visit with a plan and feeling very much better prepared because we took the time to look over the record beforehand.

USE OF THE RECORD DURING THE VISIT

There is still some difference of opinion regarding the advisability of taking the record into the home. There are some nurses who feel that the mother will hesitate to answer questions if she sees them being written down. But many public health nurses feel that, quite the contrary, the record makes the discussion seem more important to the mother. Some mothers watch the record with great interest. The items on the record can be used by the nurse as reminders to include all points in her health teachings plus the fact that making out the record in the home makes for more accurate recording and saves time.

USE OF THE RECORD AFTER THE VISIT

If every home were the same, every case and every visit followed the same pattern, it would not be necessary to use the record at any time. But we know this is not true. It is because of all the *differences* that we decide upon a plan or pattern that best fits the individual case. The plan for the next visit is based on developments in today's visit and the habit of recording briefly the date *and plan for the next visit* can go a long way towards making that next visit more productive. We will not forget what we planned to do if it is re-

corded, and it would be of the greatest assistance to another nurse making a visit for us.

And this completes the circle back to the point of using the record before making a visit. If the record is properly filled out, and a plan suggested, it is ready for use when the time for the next visit arrives, and it will take very little time to review the recorded facts and be prepared. (The record might have a definite space for writing a brief plan, or it may be recorded following the comments on progress.)

RECORD FORMS AND RECORD KEEPING

A planned, well spaced record form is essential but it must be used to be of any value. It is like talking about any policy of our organization in ideal terms and refusing to discuss actual practice. The record form may describe our policy but our record keeping reveals our practice. We need a detailed manual of instructions for record keeping, to facilitate understanding of the exact meaning of each item on the record and to facilitate comparable recording.

Records of all types of cases can be used to advantage. Time will not permit a detailed discussion of each item on other types of records, but we may cite a few examples:

Have we not all started a discussion about diphtheria immunization only to be told by the mother that her preschool child was immunized at the clinic last year? We could have checked up on that ahead of time and devoted the time to some other point, such as the importance of giving cod-liver oil during the winter months.

It is practically imperative that we use the record in the home when making a communicable disease visit to be sure that we obtain all the epidemiological information pertinent to the case.

We would all say it was very silly to visit a tuberculosis patient without inquiring about the household contacts and advising that they be examined. But unless we make a *record* of these contacts and check up on their health examinations, it could not be considered very satisfactory supervision.

And speaking of the family, how important it is in all our work to think of the family as the unit! A visit in the home is a case-finding opportunity for other types of problems. And how can we possibly remember and use the family data unless it is recorded? We could so easily visit a maternity case and forget to record the fact that there were two school children in the family. While the next visit to that home would offer an opportunity to discuss the report of the school examination, if the school child's name was not recorded on a family record or if we forgot to look at that record, we could easily start out without looking up what defects were reported for those particular school children.

The family circumstances influence our method of approach in home visiting. How can visit after visit to a home be productive if, for example, we merely continue to advise that the three school children should have defects corrected and entirely overlook the fact that the family cannot possibly afford to pay for those corrections, and knowing that there are no facilities in the community to provide that service? We might better visit once and use our records, and write down the economic circumstances and the parents' response about willingness to have corrections made. Then we could compile a list of names of parents who desired corrections for their children's defects and present this list to the authorities or interested groups as definite evidence of the need for such service in that community.

OTHER TYPES OF RECORDS

We have mentioned records other than nursing records, such as birth certificates, school reports, clinic records and the like. The nurse can use these to great advantage in bringing together all the information pertinent to the family which she in turn can use to make her contact with that family far more productive. For example, a birth certificate is not an isolated record of the birth of a child. It tells you about a family: the nationality of the parents —an index to customs; the father's occupation—an index to economic circumstances; the age of the mother—an

index to possibility of further pregnancies, or, as one nurse classifies her, a potential P.N.; the number of other children in the family—an index to the extent of health problems in that family. If, for example, the birth record states that this child is the fifth child born to this mother we may check the family name with school records and clinic records and find out before visiting the home what, if any, problems have been reported for older children in that family.

USE OF RECORDS FOR SELECTING CASES

There is another use of records in terms of making more productive visits. They may be used as a basis of selecting cases for care.

We all know, especially these last few years, how difficult it is to visit all families on our lists or to visit them as frequently as generally accepted standards of supervision may require. We are forced to make a selection and the records can be of assistance. Suppose for example, that it is near the end of the day and we have time to make only one more visit. Mrs. Martin is a very pleasant, coöperative woman; she is taking excellent care of her third baby; she follows advice; she has been eager to learn all she could, consults the doctor regularly and is always glad to see us. We have not been there for several weeks. Shall we make that visit? A look at another infant record shows that Mrs. Green's first baby was born prematurely, is bottle fed, not always according to the physician's orders, and that Mrs. Green is not very friendly and not particularly anxious to learn from the nurse, even though they are in reduced circumstances and she cannot pay for the much needed advice. After looking at these two records, which visit would you decide would be the more productive?

This kind of analysis can be carried out effectively with all our records. We must face the fact that the present ratio of nurses to population is and probably will be for a long time entirely inadequate for carrying out completely the standards of practice that have been set up by public health nursing organizations, appraisal forms and other methods. We must select the families that require in the greatest degree the educational and other services of the public health nurse. And we must extend those services to as many families as possible. To accomplish this we must look over what we are doing from time to time. This does not necessarily mean a detailed statistical analysis, but looking over a group of family records to find out, for instance, if a small proportion of the families are demanding and receiving the largest percentage of our services, at the expense of some families who are not receiving any service. The records then will assist in selecting for extensive service only those cases whose problems are relatively serious enough to warrant it.

While the illustrations given may apply more specifically to a so-called generalized program of health supervision, the principles involved may well be applied to the types of services carried on by any group of public health nurses.

The time is past when we can say we do not keep records because we do not like record-keeping and because no one ever looks at them. Adult professional workers keep records as part of doing the job intelligently and if no one else looks at them it does not matter, for we need, and want, to use the records ourselves.

Editorial note: May we call your attention again to the Handbook on Records and Statistics prepared by the N.O.P.H.N. and the Advisory Committee on Social Statistics of the U. S. Children's Bureau which may be secured from the Government Printing Office, Washington, D. C., for 5 cents.

Nurse-of-the-Month

HELEN MATLOCK

Colorado

VISITING NURSING TWO MILES HIGH

Although I was born and reared in Colorado and had my nursing education and public health experience in Denver, I must confess that I had a thrill when I was appointed to do generalized nursing in the historic old mining town of Leadville.

It was in 1929 when the nursing industry along with the other industries was feeling the beginning of the economic depression that I began my work here. Although most of the mines were silent, I could imagine them humming with activity and the gullies pouring forth gold. Compared with most mining camps, Leadville is really a modern city, though its appearance on first inspection is drab and old. It is said that "the people make the town" and Leadville, not common with most mining communities, has a most cosmopolitan population, and there is to be found among the people here a fine spirit of coöperation and a willingness to help the less fortunate.

Leadville nestles in the foothills of the Mosquito Range at an altitude of 10,200 feet. I expected to find climatic conditions two miles high severe and rigorous, but quite the contrary is true. In winter we experience the prevalent weather of the Rocky Mountain region and our summer climate is particularly delightful. Leadville's setting is beautiful and inspiring. The snowy range of the Continental Divide is visible for a hundred miles, but the hills seem close and friendly.

The work of the visiting nurse here is interesting and varied. It is especially interesting to care for the many old timers who are always going to "strike it rich tomorrow." Tomorrow has come for many of them but not riches. The quest is over, so they have become my charges, I bathe them and dress their wounds while they tell me grandiose tales of the Leadville that used to be.

There is a changing population creeping into the old town these past few years. As is frequently the case in mining communities, the population changes. Many of the mines have closed and miners have moved elsewhere to seek employment. The only smelter in Colorado is in operation here, most of the employees being Mexicans or immigrants from southeastern Europe. These immigrants have brought the nursing problems peculiar to immigrants, maternity cases, sick babies, and communicable diseases. I drive from home to home administering care and many times kind fathers thaw my engine and shovel my car out of the snow while I give care to mothers and babies. I have many maternity cases among these and I conduct a weekly infant welfare clinic. The results of this

particular work have proved most gratifying for our statistics show that the infant mortality has decreased fifty per cent in the past six years.

The organization maintaining the visiting nurse functions from local contributions and the support of a small trust fund. This fund was made possible from some of the gold that used to flow so abundantly from the surrounding hills.

Such is visiting nursing in Leadville, the highest incorporated city in the world!

Teaching Content of Postpartum Visits

EDITOR'S NOTE: *There is nothing editors desire more than constructive comment on what appears in the pages of a magazine. Only rarely does such comment reach our desk unsolicited. This is one of those rare occasions. The staff of the New Haven (Conn.) Visiting Nurse Association became interested in the outline of* Teaching Points *published in our March (1934) number (see page 129) which was the work of another staff (Scranton, Pa.) and prepared these practical suggestions—not, as they say, to tear down, but to build up. In turn, the New Haven staff presents two of its own outlines of suggestions for the nurse in relation to sex education which will appear in November.*

The Scranton Visiting Nurse Association replies to New Haven in friendly spirit.

The Editors will welcome comment or new outlines on other topics.

AS an association we were very much interested in the article on "Teaching Points for the Postpartum Period" published in the March (1934) issue of PUBLIC HEALTH NURSING, since a group of our own staff was also working on teaching aids for the maternity service. While we do not agree with it entirely, we have found the Scranton presentation exceedingly stimulating.

Although we appreciate the fact that flexibility of teaching and adaptation to individual situations are stressed, we still question the amount of material outlined for day to day teaching. Perhaps the day's outline is meant to be suggestive of material which is pertinent from which the nurse is to select that which is most applicable to the given case. If so, we should consider the outline most comprehensive and helpful. If, however, the outline is supposed to be followed with the idea of introducing as much of the specified content as possible on each visit, we question the advisability of scheduling so definitely the material to be taught at specified times. We feel this method does not allow sufficiently for recognizing the needs as the mother sees them; nor does it take into consideration her limited capacity to absorb new material. We feel that such a plan might result in misguidance for the literal-minded nurse, and in frustration for the nurse who is sensitive to the patient's own need to learn.

Our group is attempting to solve the problem of maternity teaching by making our own content richer and more scientifically sound, and by spreading the instruction called for over the entire period of supervision as the occasion and opportunity for it arises. This plan, we feel, will enable us to individualize the teaching to the greatest possible extent, both as to timeliness and in response to the mother's recognition of needs. Beyond our ability to awaken her own desire for advice, can we hope to attain results anyway?

May we also raise some questions on the content of the material. For example, on the "First Day": "If the patient has not been carried during the prenatal period, stress the value of prenatal care and how it simplifies aftercare, etc. Tie up with present condition as to nipples, etc." As our nurses have used this technique it has raised the question: Is it wise to imply criticism of the patient on the first visit?

Would it not be possible to obtain the same results by either allowing the mother to deduce them for herself by showing her that we can be of use in the present situation, or later when the contact is more firmly established suggest other situations including prenatal care in which we can help?

Again, on the "Third Day": "If mother is able,

a. Discuss other members of the family, thus getting a better picture before making suggestions as to health. Mother may be so uncomfortable on the third day that she welcomes conversation beyond herself.
b. Physical condition of other children.
c. Habits of other children.
d. Attitude toward the new baby."

While we appreciate the thoughtfulness behind the statement, "she welcomes conversation beyond herself" and while in individual cases we can see that such discussion as suggested might relieve a given mother's worry, we think that in the majority of cases on the third day it would be wiser not to introduce subjects that might remind the mother of other responsibilities. We would put the emphasis on the nurse's attitude being such that the mother would introduce them herself if she felt the need.

On the "Fourth Day": "Potty training—tell mother about it for later use." Because our experience seems to support the theory that the wisdom of starting potty training in the early weeks or later months depends so entirely on the mother's emotional reaction toward it, we would not want to introduce the subject until we had an opportunity to evaluate the mother's attitude; and we would feel, if the whole subject of toilet training had not been introduced in the prenatal period, it should wait until well past the fourth day.

On the "Fifth Day": "Thumb-sucking and how to prevent." If thumb-sucking is looked upon as a natural phase of infancy, do we want to make such a point of "how to prevent?" Had we not better put our emphasis on establishing a happy atmosphere for the baby and satisfactory habits of eating, resting, and playing, expecting thus that the need for thumb-sucking will lessen of its own accord?

On the "Sixth Day": "Food fads and how to guard against." We would prefer the more positive approach. If by food fads are meant herbs and teas and the like, occasionally advocated by friends, we think that emphasis on the positive teaching that breast milk and water are best for the baby is sufficient, and if by food fads are meant the later eating habits, we feel that the emphasis during the first weeks should be on the formulation of positive habits rather than warning against later difficulties that positive teaching might well prevent.

On the "Seventh Day": "Sex education and how to present same." We would be interested in the interpretation of the Scranton Visiting Nurse Association and other organizations of "how to present same." We have worked out a guide which suggests opportunities for incorporating sex education in our general nursing and health teaching, and we would like to submit this for criticism and suggestions from other organizations. (To be published in November.)

In closing, may we express our admiration for the thoughtful and comprehensive analysis of work. We are fully aware that it is much easier to criticise the result than to work out a guide such as this, and we congratulate the Scranton staff on its product.

The Scranton Visiting Nurse Association replies:

No more salutary signs of growth could be observed in the public health nursing field than two organizations working simultaneously on teaching points. Interestingly, both the New Haven and the Scranton Visiting Nurse Associations have selected the postpartum period, where the bulk of their work falls, to analyze for content and method.

New Haven very rightly interpreted the material outlined as being intended to increase the flexibility of the nurse's recognition of the mother's needs. Certainly, we wish to emphasize that it was never intended to stultify her efforts. The primary law of individual differences must become so basic to the nurse's understanding of each situation that the gathering of suggested material cannot swerve her from this fundamental law of all teaching.

We feel the specific questions raised on the content of the first three visits prove the value

of research criticism from other groups who have been doing like thinking. We must guard against this content being taken too literally by any nurse, as these suggestions mark danger posts.

We feel, however, that we must clarify the remarks intended for the Fifth and Sixth Days. "Thumbsucking and How to Prevent It," points to just such suggestions as the New Haven Visiting Nurse Association has emphasized on "establishing a happy atmosphere for the baby and satisfactory habits of eating, sleeping and playing."

We have used, what we have discovered is a colloquialism in stating, "Food Fads and How to Guard Against." This has meant to our staff, not herbs and teas and the like, but rather, a capricious appetite, which may be guarded against by the spoon-cup-bottle education, and by a consistently casual attitude in offering new foods in small quantities, and by the mother's understanding that it is better for the child to miss a meal or a bottle than to acquire the habit of refusing foods. Hunger, rather than forcing, is the answer to "finicky" appetites. It is the strong feeling that the prevention of all anorexia rests in the way the food situation is handled in the first two years of life, that brings us to describe this danger to the mother, and to put her on her guard against food situations that arise in the life of every normal infant.

We are looking forward to the amplification of the material to be employed on the Seventh Day—"Sex Education and How to Present Same." We hope that many other organizations will follow New Haven's lead in working out specific suggestions that have been handled vaguely by various nurses with widely diverse results. We must build up an acceptable body of content before we can hope to have our nurses applying the more abstract laws of their teaching methods. It is with this thought that the Scranton Visiting Nurse Association originally embarked upon outlining a day-to-day teaching program.

ANTISEPTIC TEARS

"There is very little understanding on the part of the public as a whole that a most potent antiseptic agent is supplied to the eye by natural means: that is, by the tears. Laboratory experiments have shown that for most disease-producing organisms, normal tears are hundreds of times more effective in protecting the eye than solutions of drugs in such strength as can be borne. The tears are supplied in amounts that are properly regulated, and counteract the effect of most air-borne bacteria.

"Because the general public has learned that many eye lotions are put up in a solution of boric acid, the better informed immediately turn to this solution as the one safe substance that can be used for any disorder of the eye. Hence, we find that many people are using an eye cup, giving the eye a daily bath in boric acid solution, in the hope that their disorders will soon pass away and the necessity for visiting a physician may be obviated.

"The healing properties of boric acid are infinitesimal. It is used chiefly by physicians as a vehicle to carry small dilutions of more potent drugs; and because it retards the growth of fungi or of contaminating bacteria, it forms a convenient way to dispense medicines for the eye. There is not sufficient reason for the regular use of eye baths, as there may be for cleansing the teeth or gargling the throat. The practice of giving eye baths with any solution when eyelids are not diseased, except on the advice of an oculist, should be discouraged."

—Dr. William L. Benedict in *The Sight-Saving Review*.

THE NEXT CONVENTION

The Boards of Directors of the three national nursing organizations have accepted the invitation of the nurses of California to hold the 1936 Biennial Convention in Los Angeles. It will be fourteen years since the Convention has been held on the coast and plans are already under way to make the meeting a noteworthy one.

Rural Health Work in the Philippines

By MARJORIE SPRING BOOKER, R.N.

Mrs. Booker, after several years of experience in public health nursing in the United States, has married and is now living in the Philippines, where she still maintains an active interest in the public health program.

BARE toes of one foot curled over a rough cocoanut husk and the toes of the other grasping the floor, my husky little Bontoc housegirl polishes the wide native mahogany floor boards of my verandah. Back and forth she skates with a rhythmic "shush shush" that makes me sleepy. Macli-ing is mission school trained and speaks excellent English but she is the child of a mountain tribe famous not so long ago for its head-hunting proclivities. Although she is a native "Filipina", her tribe differs as widely from the small-boned lowlander enervated by the heat into the delicate little brown person considered by Americans as the typical native, as it does from the war-like Mohammedan Moros of the south.

To understand the people of the Philippines one must know something of ancient Malay culture, of primitive religions and customs—something too of the race psychology evolved from them all. To comprehend anything of the obstacles and difficulties which face public health workers in these islands one must have a working knowledge of the inhabitants and the geographical conditions.

Around me are hills green with pines; below me is one of the many rivers of northern Luzon. Valleys are semi-tropical, with giant tree-ferns and lovely moths and butterflies. On a nearby hill straggles an Igorot village, its shacks an extraordinary patchwork of bamboo, sheet iron, boards and a tuft or so of grass. Rusty tin scraps keep the thatched roofs from blowing away in a typhoon.

Many of the Philippine Islands are volcanic. They number over three thousand, about one thousand of which are inhabited and cover an approximate area of 183,000 square miles. The total population as computed in 1933 was about 13 million persons. Although the Islands are located in the tropical zone, climatic conditions range from heavy frosts in the mountains with an 8000 or 9000 foot elevation, where pines grow and the seasons are alternately wet and dry—to the hot wet lowlands and the jungles. Some islands have perpetual rains, others, notably Mindanao, are of equable temperature and have moderate rains all the year.

THE PEOPLE AND THEIR WAYS

All the tribes of the Islands except the Negrito are Malay in origin although they came by successive migrations—the Negrito the first, then—over a thousand years ago it is estimated—came the hill tribes of today; the lowlanders followed and last came the Moro people.

The Igorots, by whom is meant all the hill tribes of the Mountain Province, live in small bamboo and grass houses with an earth floor unless the house is elevated; the ceiling is effectively sealed air-tight by the layers of greasy soot from the cooking fires. There is no chimney and on cold nights additional fires are kept burning in the closet-like sleeping room. To keep out the *anitos*

(evil spirits of ancestors) windows are tightly closed at night.

There are no sanitary arrangements as a rule; a board over the pigpen is often the toilet. Waterfalls and rivers form showers and laundries; chill winters make baths infrequent. As a Bontoc Igorot naively remarked, "It is your custom to be clean—it is ours to be dirty."

Speaking of babies—while they are very young they are never left alone; usually they are carried constantly on hip or back by some member of the family lest an *anito* possess them. Their food, as soon as teeth arrive, consists of rice, chewed by the mother and, bird-like, placed directly into the child's mouth from hers. They are weaned at a year or so and then promoted to the family menu.

This food consists chiefly of very odorous dried fish and rice; camotes (sweet potatoes) and beans are used less often. Fresh fish and occasional greens are eaten. Meat, whether chicken, pig, dog or carabao (water buffalo) is cooked only for ceremonious occasions; the amount of food then depends on the wealth of the tribe or individual. Upon death, marriage, a new house, for good hunting or fishing, for fertility or to propitiate the gods, these *canaos* are given. Victorious head-hunting *canaos* are the greatest. It is an awesome sight to watch, in the glare of firelight, the rhythmic posturing of naked bronze pagans to the beat of brazen gongs.

Negritos also live in the mountains on a number of the islands. Little is known of the origin of these wooly-haired pigmy blacks who resemble peoples found in parts of Indo-China and Asia. They live in complete savagery far back in the hills and jungles. Nothing is known of their habits and customs, they are so shy and wild.

A native home elevated for protection

We now come to the people of the lowlands—the eight so-called "Christian" tribes, as distinguished from the pagan "wild" tribes and the Mohammedan Moros. These tribes are divided into innumerable lesser ones, each with its own dialect; there are three however that are commonly used. It is the lowlander who has been in contact with the white man since the advent of the Spaniard. Predominantly Catholic, inclined to attend school where he is taught a sort of English by Filipino teachers, he is a product of external civilization.

Since bathing is a necessity where the heat is so intolerable, the lowlanders are forever washing themselves and their clothes in the rivers. It is extraordinary

to see how neat the women can be in their "Mother Hubbards" or in the more picturesque Spanish draped skirt and butterfly blouse—and how immaculate the men in American whites.

Everywhere one sees the men, women and babies smoking the strong native tobacco leaves rolled loosely into huge cigars. In many homes the family cigar is hung by a string and is puffed by all who pass! Mouths bloody looking from red betel-nut chewing, too, are a common though rather startling sight.

Briefly I have tried to describe the four principal groups of natives—the Negrito, most ancient and most primitive—next, the hill tribes who live on many of the islands—I have used the Igorot of Northern Luzon as an example; then come the Christian tribes and last, the Moros.

Social groups embrace the educated "Mestizo" class, interbred with Chinese, Spanish and American, who form the ruling political group and the large part of the professions, down through the lesser officials who are usually lowlanders—to the teachers, tribal rulers and so on, until the *tao* class is reached. Peasant, sometimes slave, he forms the greater—and submerged—part of the people. Whether he is plowing his rice terraces with a pointed stick in the mountains, working in the sugar cane or gathering bananas and cocoanuts in the lowlands—whatever his gods—everywhere he exists. It is of his group that I write.

MODERN HEALTH WORK

Modern health work in the Philippines was begun by the American Government and later the Red Cross became very active. Missions too were instrumental in the establishment of hospitals and in education. The combined work of all the health agencies has resulted in the control of communicable disease—especially the dread cholera and smallpox. Vaccination in the schools is compulsory.

Filthy river water in many towns and small *barrios* has been replaced by artesian wells; sanitation has improved wherever civilization has been effective, but the inaccessibility of most of the rural population and the ignorance and extreme poverty of the people have made such work slow. That there are educated, clean and well-to-do people is, of course, hardly necessary to say—but in comparison to the number of the

Igorot woman with her baby

tao class and the primitive conditions under which most of them live, that upper group is negligible. Education is progressing and conditions have improved but it will require many generations to civilize the Islands completely.

The Philippine government and the American Red Cross are not the only agencies doing health work. The large mining companies are helping too. Each must, by law, maintain a hospital, doctor and nurse. Living conditions are infinitely better than in their native *barrios;* mine workers must live on company ground, the majority in neat tin houses. Good sanitation is rigidly enforced; cottages are inspected by the nurse for cleanliness and communicable disease. Medical care is free, but it is

difficult to get the native to a doctor until all his magic rites have failed. In some camps there is a little infant welfare work being done; this will grow, I am sure, for intelligent native women through their clubs and schools are becoming interested. Since pay, by native standards is high in the mines, food is plentiful if not wholly adequate for health. The thin woven blanket of the Igorot and his bed of warm ashes on cold nights are being replaced by company blankets of wool. Above all, the water supply is frequently tested and there is a sewage disposal system. Natives do have the more serious forms of dysentery and they have typhoid. The rock formation and general pollution of all streams make even many springs unsafe.

THE WHITE MAN'S CONTRIBUTION

In every hinterland, every savage island that the white man has set foot, he has brought with him the scourge of tuberculosis. Like measles and chickenpox to these people who have acquired no immunity, it has meant death. Aided by their crowded houses, their inadequate diet, common food and drinking vessels and their unclean habits, tuberculosis has become a dangerous and a stubborn foe. In spite of health work, better sanitation and education, it is on the increase. To quote an interview with the Bureau of Health published in the Manila *Bulletin* August 18, 1933: "Pulmonary tuberculosis is increasing in the Philippines, a survey completed yesterday by the Bureau of Health indicates. The disease still constitutes the country's major medical and sociological problem. Far from being reduced, the incidence of the disease has gone up from an average of 214.02 per 100,000 Christian population at the end of the five-year period ending 1910 to 275.08 at the end of the five-year period ending 1930. The average for the last two years is still high, with a total of about 30,000 in round numbers." These figures are probably far too low.

The physicians in most parts of the Islands are either medical missionaries, Public Health men, or connected with the U. S. Army. The Philippine health service provides for the annual examination of all school children according to law. Although education is not compulsory, children are eager to go to school and parents to have them, but the upper grades and the high schools are not so well attended and the school system lacks funds for all who would attend. The Moro land has few schools and these are for the most part their own religious schools, not a part of the government system.

Here again in the schools the workers are hampered by the almost total lack of local facilities. To be so limited is very discouraging to the devoted nurses and doctors. Of great help has been the Junior Red Cross Dental Service, begun in 1922, which is receiving increased support. During the year 1933 a total of 93 clinics were in operation; 184,484 of the total number of 283,599 children found with defective teeth received care, while 379,539 were given dental prophylaxis; 404,633 children were examined. The dental staff is composed of qualified dentists who have a special course in the work of health teaching. They conduct classes, give talks and hold parent conferences and advise teachers.

RED CROSS ACTIVITIES

The American Red Cross plays a very important part in all the health activities of the Philippines. This chapter is the second largest in the Orient and Asia—Japan's is the first. There are forty-nine active provincial branch committees; all money raised here is spent here. General Headquarters in Washington, D. C., pays the American manager and two members of the staff. At present there is a staff of 74; this includes a Director of Nursing, one instructor in Home Hygiene and Care of the Sick who is also the supervisor of the municipal staff, and three field representatives.

After municipalities had taken over much of the infant welfare work, the Red Cross enlarged its school health activities in coöperation with the Bureau of Education and the Philippine Health

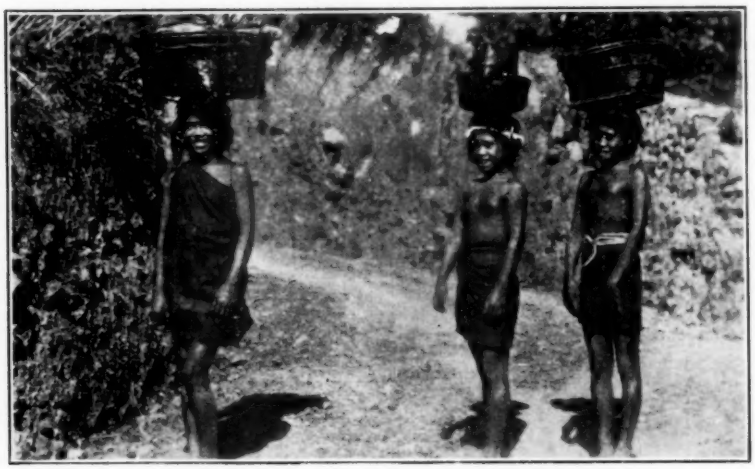
Service. Today there are 58 full-time nurses employed in the Red Cross school and community nursing service and 86 public health nurses employed under the Bureau of Education as well; 377 nurses, not under the Red Cross, are doing field work in municipalities and mining communities and in puericulture centers.

The Bureau of Agriculture, through its schools and teachers has done good work in teaching the value of vegetables and how to plant them; and all school teachers are taught to emphasize nutrition in every possible way.

The nurse's life in the remote regions of these islands is an adventurous one. One nurse writes: "Have you ever been capsized in a small boat? Have you ever slept under the open sky among bushes along rivers where man-eating crocodiles are frequent visitors and your only companions are the *cargadores,* or burden-bearers, who are pagans and still have the reputation of being head-hunters? I wonder if you, in like situation, would go peacefully to sleep as we must do to be ready for the next day's journey. . . "

And from another report: "Six Igorot men came for me. I was a little afraid to go with them until they showed me a letter from the teacher wanting me to go to Bagu at once for a woman had met with an accident. I knew that the road was difficult and dangerous but it was a test to prove I was ready to answer a call at any time. We left at daybreak. The river was in flood so that my companions told me to cross the river by using the hanging basket, which was not very safe; the other way was even more dangerous. When I was ready the men pulled the rope slowly on the other side of the river until I was across. I had a hard time getting out of the basket as there was no place on the bank on which to put my feet. We then climbed a high and steep mountain. When I could climb no farther two men carried me in a chair tied on two bamboo poles, my feet higher than my head as we went up. When we reached the top, there, almost buried in a very deep canyon, was the *barrio.* I preferred to walk down than to go head first, so, trembling and using a bamboo cane, I reached the house, treated a dislocation and bruises and left for Bakum with seven men accompanying me.

"I decided to cross the bridge this time. When I began to step from one high pile of stones to another my feet trembled as I saw the swift current and deep water. I had to stop until four men came to help. The ladder to the bridge



Bontoc girls coming home from market. Note dog-tooth necklace in child's hair

was weak and shaky and I thought we should never get across that narrow swaying bridge. . . . . "

Readers may wonder where nurses doing such responsible and difficult work get their training. All field nurses are Filipino born and most of them are trained in Manila hospitals. In connection with the University of the Philippines some work may be obtained in public health and the Manila supervisors lecture on school nursing, while practical field work is obtained in the Manila schools which are under the health supervision of the A. R. C.

The Red Cross in the Philippines has many disasters for which it must supply relief. During the last ten years this chapter has extended relief to 1,557,618 people and during the last ten years has spent over $2,000,000 for humanitarian service. Typhoons on the seacoast, volcanic eruptions in the mountains and great conflagrations in the palm-shack villages require a great variety of aid. Nurses, when needed, are relieved from duty for such emergency work.

Disaster relief was the means of establishing a very important health service in the Philippines. In November, 1928, after a very severe typhoon had destroyed crops and homes, the A.R.C. at National Headquarters gave $50,000 for health and relief work in the stricken areas. Five "Health and Relief Units" were established. Each unit consists of one doctor, one dentist, three nurses, one agriculturist furnished by the Bureau of Agriculture, one stenographer and two helpers. They move from place to place, staying only long enough in each village to do an effective piece of work. It is hoped to make this work permanent in each locality.

Early in 1932 the Philippine chapter of the A.R.C. took over the work formerly carried on by the Philippine Anti-Leprosy Society. The chapter maintains a social worker in Culion and in Cebu as well as at headquarters in Manila. Assistance is given to families of segregated lepers and to ex-lepers under parole. Through the Red Cross Auxiliaries, nursing and dental service contacts are made throughout the Islands with the families of the afflicted people. Leprosy is not common now and there is far less opposition to the removal of the affected individual.

Public health work is very young on these islands but already an enormous amount of work has been accomplished in spite of difficulties which would daunt a less courageous group of workers. No longer are whole islands depopulated by smallpox and cholera or bubonic plague. Lepers no longer freely roam the villages. Water supplies and systems of sanitation have been vastly improved, especially in Manila and the larger villages. Malaria is being successfully combated in many places. Above all, by means of painstaking education a consciousness of the truth of health teaching is slowly growing. Here we have, remember, vestiges of utter savagery—down through the stages of culture from the stone age to the age of metals—and we have Manila, with its Spanish charm and its cosmopolitanism, with its air service, radio and world telephone connections, its beautiful buildings, colleges and churches. But just a little way back from these borders of civilization lie the bamboo hut, the common rice bowl, odd customs and, in the hills, the rumor of head-hunting and strange dances.

BOARD MEMBERS PAGE

Edited by MRS. KATHARINE BIGGS MCKINNEY

A MANUAL OF INFORMATION FOR BOARD MEMBERS

This year instead of an outline for a study program, the Executive Committee of the N.O.P.H.N Board and Committee Members Section is suggesting a manual of information as a project for local education committees. The board of the Detroit Visiting Nurse Association has an excellent mimeographed manual of information for board members which it has shared with us and the following outline for a manual is an adaptation of it with additional ideas and suggestions from our N.O.P.H.N. Committee.

The Education Committee should advise each board member to secure a loose leaf notebook for the material which is to be worked up, and if possible mimeographed, for ready reference. Data can thus be added from time to time and brought up-to-date as changes occur, such as information concerning legislative measures, etc. The Visiting Nurse Association of New Haven, some six years ago, had a printed pamphlet called "A Board Member's Guide" with a map of the city in it as well as general information. Charts and graphs can be mimeographed if your group wishes to present more elaborate material. The important thing is to have available for each new member coming on the board and for the older members, correct and up-to-date information about the health resources of the city and the work of the organization they are administering. Some of the material that answers common questions may be noted on cards that can be carried in the pocketbook, a method followed by community chest campaign workers.

The outline given here is merely a suggestion. Your own Education Committee can add or subtract from it as seems best.

WHAT EVERY BOARD MEMBER AND VOLUNTEER WORKER SHOULD KNOW ABOUT

..... (Name of organization)

Address ..... Telephone Number.....

I. *General Information*
- A. Population of (City or County)
- B. School population
- C. Vital statistics City State
  1. Maternal death rate
  2. Infant death rate
  3. Tuberculosis death rate
  4. Birth rate
- D. Program of State Department of Health: Relationship of your organization to State and County health program

II. *Health Resources*
- A. City or County Health Department
  1. Budget
     What % of the tax dollar?
  2. Size of professional staff (List —give qualifications)
  3. Services
- B. Hospitals
  1. Beds available: Free Pay
     a. Adults
     b. Children
     c. Newborn
     d. Communicable diseases
- C. Clinics: Free Pay
- D. School Health Program
  1. Budget
  2. Staff
  3. Services
- E. Other public health agencies such as Council of Social Agencies, Tuberculosis Society, Red Cross, etc.

III. *Your Organization*
- A. History
  1. Organized (Date)
  2. Incorporated (Date)
  3. Constitution and By-Laws (copy)
- B. Territory covered
- C. Is organization member of following organizations
  1. Community chest
  2. N.O.P.H.N.
  3. Other
- D. Board of Directors
  1. Number of members
  2. Term of office
  3. Time of board meetings
  4. Number of committees
     a. Standing (List)
     b. Special (List)
     c. Advisory (List)

E. Staff
1. Number
2. Positions
3. Qualifications for staff members
4. Personnel policies
5. Vacation policy
6. Sick leave policy
7. Salary scale
8. Insurance—(Accident, sickness, other)
9. Uniform equipment
10. Hours of duty
11. Educational program for nurses for current year

F. Program of organization
1. Service program
(Such as bedside nursing, health supervision, etc. describing what the nurse does)
2. Coöperative program with other health and social work organizations
3. Relationship to Medical Society
(Statement of Standing Orders, etc.)
4. What is cost per visit
What is charge per visit

G. Finances of organization
1. Source of income Amount
a. Patient fees (By year or month)
b. Service contracts
Metropolitan Life Insurance Co.
John Hancock Mutual Life Insurance Co.
Public Departments
Other
c. Community chest or financial drive
d. Private contributions and memberships
e. Endowments
f. Appropriations
g. Other
2. Disbursements
a. Rent, heat, light, etc.
b. Salaries
c. Transportation
d. Other

H. Committee functions
(List and describe the program plan for each committee in detail showing what publicity is available about organization and what the volunteers are doing in the program)

If the secretary of the N.O.P.H.N. Board and Committee Section can be of help to you in any way in preparing this manual of information and its use, please do not hesitate to call on her.

There are several books of special interest to board members reviewed in the Book Notes department this month. May we also call your attention to the articles on pages 515, 518, 525.

HORSE AND BUGGY DAYS

The Public Health Nursing Association of Peoria, Ill., carried out a novel plan for publicity on the anniversary of its thirty-first birthday. A full page was secured in the Sunday *Journal-Transcript* and early pictures of the founders of the association were published covering more than half the page, with an account of the founding written by the executive director which filled the rest of the page, closing with a list of the present board members. The pictures show the styles of dress and millinery dating from the 1900's. They were collected by one of the board members from the ladies themselves or relatives and aroused wide local interest.

The N.O.P.H.N. has copies of this page which may be borrowed on request.

"TO BE CONTINUED"

Six stories were printed about the services of public health nurses which would be continued if funds were furnished. The stories were brought just to the point where the reader's interest was at its height and then one read: "Help us to write the next chapter."

WITH PACKAGES

We have heard of having appeal folders or fliers sent out with gas bills, tied on milk bottles, delivered with laundry, printed on loan library book covers, placed in hymn books and on church calendars, but to have the message stamped on the paper bags of grocery and department stores was a new one.

JUST STOP AND THINK!

In asking for small weekly donations of from ten to fifty cents, an agency listed the amount usually spent for cigarettes, ice cream sodas, chewing gum, movies, daily papers, etc., per year, to compare with the amount the contributor planned to pledge. By supplying small cotton bags with draw-strings (like money bags) the agency encouraged school children "to fill the bag" with small change for the community chest.

SCHOOL  HEALTH

THE MODERN ELSIE SERIES FOR THE SCHOOL HEALTH SECTION, 1934-35

Starting this month, October, 1934, the School Health Section of this magazine will embark upon a totally new approach to school nursing problems. You will be introduced to Miss Elsie Carling, R.N., school nurse in the School System of Oxford, Everystate. Miss Carling is facing a school year of unusual difficulties, she has had some experience in school nursing but not so much but that she still makes mistakes and still has a lot to learn. She runs up against the familiar snags of indifferent parents, impatient principals, critical doctors and problem children—in short, she is a typical school nurse who is learning through hard experience how to handle her job. The point of it all is this—we want you to help Miss Carling! If, when you read about her problems, you know a better way or a different way to handle her situation, please write to Elsie Carling, care of this magazine. We are going to see that Miss Carling faces the same sort of school difficulties you are facing and *finds a way out*. If you think she is escaping your pet problem, send it in and we will see that she finds it sitting on her desk Monday morning.

Needless to say, after this introduction, you will have guessed that Miss Carling is a fictitious school nurse, created by the imaginations of the Chairman of the N.O.P.H.N. School Nursing Section, the education committee of this section, and the editors of this magazine. With such synthetic parenthood and sponsorship it seems as though she might be of value to you in your work. Anyway, she is looking forward to meeting you.

I

SHE COULD AFFORD HER OWN, THANK YOU!

It was Monday, 8:30 a.m. in the fifth week of school. Elsie Carling, School Nurse in School No. 80, in Oxford, Everystate, sat perfectly still at her desk rereading for the third time the note she had found tucked in her blotter. It was from Miss Worth, one of the teachers, and it really did not need rereading, it was so very clear. It said:

Miss Carling—

John Frey's mother came to see me after hours Friday. She was highly indignant at the note you sent her about John's eyes. She says she can take care of the health of her own children and she will trouble you to leave them alone. She says she will not take John to a clinic, she can afford her own oculist, thank you, and she ordered John not to go to your office again under any conditions. I tried to calm her, but she was very angry and as you had not told me what was the matter with John's eyes, I could not give her any advice. She went from me to the principal's office and said she would carry this matter to the school board and have you put in your place. You'd better see Mr. Thornton the first thing Monday morning.

M. E. Worth.

Mr. Thornton was the principal. So far this year he had barely spoken to Miss Carling, the school work had started off with such a rush. She had had one brief conference with him on program and reviewed her list of needed supplies, but that was all—now this mess! Mrs. Frey, angry; Miss Worth peeved; Mr. Thornton ready to dismiss her perhaps! All because she had sent a report card to John

Frey's mother saying the school doctor had found John's vision defective and would she please see that John's eyes were examined for glasses either at a clinic—and she had sent the time and place—or by her own oculist! Harmless enough, surely, what was the mother fussing about? Well, she must see Mr. Thornton as soon as she could.

At 11 a.m. she went to Mr. Thornton's office. Miss Worth was there, too. Miss Carling reported what she had done at the school doctor's request. Miss Worth reported Mrs. Frey's visit and Mr. Thornton added what the irate lady had said to him.

"I'll be perfectly frank with you, Miss Carling," Mr. Thornton said, "I don't know much about your health program but I'd like to ask you some questions. Had you ever met Mrs. Frey or been to her house?"

"No, Mr. Thornton, this is John's first year here, he was transferred from No. 72 and this was the first time he had come to my office."

"So you did not know what kind of a home he came from. Did you invite Mrs. Frey to be present at his examination?"

"Well, just the general invitation that went to the P.T.A. the first week of school—not a personal invitation."

"Did you send her a note about John or the routine report card?"

"The card—I haven't time to——"

"Time—um—I wonder—well, about reporting to the teacher of a child with a vision defect—what routine do you follow?"

"Each week I send each teacher a list of the children examined and a report on the conditions the doctor finds. John was examined on Thursday and Miss Worth will receive the report for him and the other children from her room today. It's a weekly report."

"After this I think you'd better report to the teacher before you send a note to the parents, and I'd suggest that you try harder to get the parents to come in when their children are being examined. Dr. Landis could talk to them and relieve you of some of those notes. And try to know home conditions before you suggest free clinics. Mrs. Frey happens to be perfectly able to pay her oculist. She is an intelligent woman and I suggest you get her on your side. Maybe you could get the health committee chairman of the P.T.A. to put her on the Health Committee. Have you any suggestions, Miss Worth?"

Miss Worth had been sitting on the edge of her chair. Now she exploded—

"Yes, I certainly have, Mr Thornton. I want it made clear whether I am in charge of the health of the children in my room or Miss Carling. Do I care for all of their needs or only those unrelated to health? Where does one stop and the other begin? Shouldn't I know everything about my pupils in order to do a half-way decent educational job? As I see it, Miss Carling is the specialist to whom I refer for advice and help, but I ought to have a definite health program for my room. I ought to notice if John can't see the blackboard, I ought to report sore throats, splinters, overfatigue to her. I ought to ask for reference reading on the health aspects of special projects, just as I now do the weighing in our 'Growth Campaign.' Am I right?"

Mr. Thornton had been pawing among his papers. "There's a report here from the White House Conference on Child Health that came in sometime ago—it seemed good—if I can find it—here! How's this statement:

> " 'The health program of the schools should be definitely and fundamentally educational in nature and scope.
>
> " ' . . . No service should be performed in such a manner that it takes away fundamental privileges or responsibilities of the home in relation to its children.
>
> " 'Any policy that does for the individual what he can do for

himself leaves him more dependent and less able and willing to care for himself when the protective hand is withdrawn.'

"Now that's the way I see it. I suggest you and Miss Worth meet right away with the other teachers and outline ways in which Miss Carling can be of service this year to the teachers in integrating health practices, information and care during the school hours. Also, I hope you work out a speedy reporting plan, Miss Carling, and a friendly note to parents inviting them to the doctor's examinations. You might wait a few days, then visit Mrs. Frey and explain things to her. Be sure to praise John—he really is a fine boy."

"Yes, I will, Mr. Thornton, thank you, and, Miss Worth, at a recent nurses' meeting I saw a loose-leaf notebook with health material of all kinds for reference for the use of teachers. Do you think that kind of thing would be useful to you?"

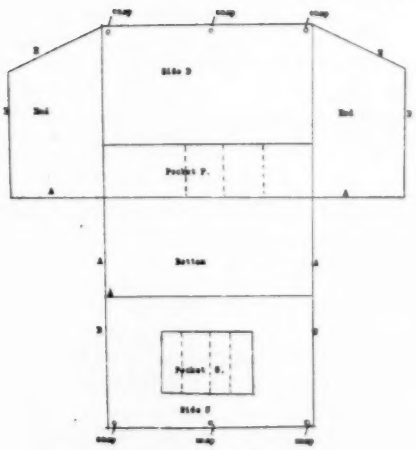
"It would be fine, Miss Carling, and I am sorry I did not tell you what I knew about John Frey's mother. To tell the truth, I had one 'run-in' with her the first week of school. She wanted to have John excused from school a half hour early so that her part-time maid could give him his lunch before she left for the day. I knew Mrs. Frey was touchy and she hates having to send John to public school. I might have warned you about her and then you would have gone to see her instead of sending a form card."

Back in the office, Elsie Carling took out a small black notebook labeled *Things To Be Done*. She wrote in it:

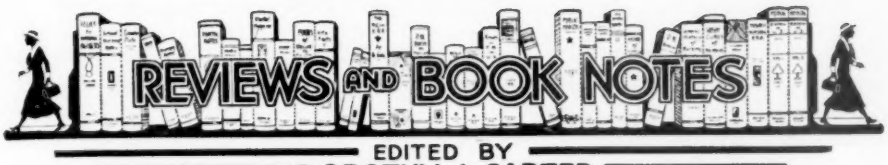
(1) Meet with teachers and plan program for year.
(2) Make reference notebook of health materials for teachers.
(3) Meet with P.T.A. and stress presence at health examinations and prepare informal invitation to parents.
(4) Know home situations better.
(5) Ask teachers for their slant on defective children.
(6) Report doctor's findings promptly to teachers at same time or before I notify parents.
(7) Plan to make all I do "fundamentally educational in nature and scope."
(8) Plan to transfer to teachers or parents all possible responsibility for the children's health.

Series II in November: When Does First Aid Cease to Be First Aid?

BOSTON BAG LINING



We are indebted to Elva Anstead, R.N., Board of Health, Gary, Indiana, for this pattern for the lining of a Boston bag. The lining is made with a double thickness of unbleached muslin. The "Bottom" is the same size as the bottom of the bag, the height of the short side (B) is equal to the side of the bag when closed. A is stitched to A, B to B, side D closes over side C with large snaps protecting the contents of the bag, and edge E folds under when the bag is closed.



EDITED BY
DOROTHY J. CARTER

HEALTH EDUCATION IN AN AMERICAN CITY

By Louise Franklin Bache. Doubleday, Doran & Company, Garden City, N. Y. 1934. $2.00.

A definite plan, accuracy of aim and a system of appraisal are the identifying features of a health education program today as compared with that of a generation ago, according to Dr. Kendall Emerson. Judging by this criteria Louise Franklin Bache's new book, "Health Education in an American City" is an oasis in the desert for those of us who are seeking the most effective ways of arousing public interest and understanding of and participation in health work. The book is not an exhaustive study of all possible methods of publicity but does give a comprehensive survey of those methods used in Syracuse, New York, when in 1923 a health demonstration was undertaken.

The account of the five-year program as told by the former director of the Bureau of Health Education in the Syracuse Department of Health is full of actual experience. It is particularly helpful because it is not limited to just the glowing successes. Those experiments which proved to have less favorable results are also given and are followed by an analysis of reasons for this. Recommendations are also made for a different plan or variations of the one under discussion.

It is all the more helpful to us because Miss Bache first gives a picture of conditions found at the beginning of the demonstration, then the steps taken in developing the program. She relates how the work was carried on through the newspapers, the distribution of publications, through a speaker's bureau, with a full and most interesting discussion of its plan and effectiveness; also through health exhibits in department stores, contests and other projects in schools, churches, societies and clubs. As Dr. George C. Ruhland, Commissioner of Health in Syracuse, says—"A great campaign of public education was organized under the slogan 'Syracuse wishes you well'." The way the slogan was chosen is of no little interest to the reader.

The illustrations in the book are clever. The appendix offers concrete samples of stories and monthly outlines of programs of public interpretation, as well as other definite suggestions for creating an informed public opinion. It is a readable book, the more valuable because of Miss Bache's frankness in relating her experiences. Her account of different activities and methods tried and explanations of why some were found more effective than others is refreshing.

HELEN BEAN.

The National Emergency Council has issued a *Manual of Emergency Recovery Agencies and Facilities* telling how to use effectively, speedily and directly the emergency services which the U. S. Government has established. To purchase send $1.50 by check or money order only, payable to the Superintendent of Documents and addressed to the National Emergency Council, 300 Commercial National Bank Building, Washington, D. C.

Board and Committee Members! Those of us who shun soliciting for money will do well to read the leaflet, *The Elements of Success in Soliciting for a Cause*, as explained by Mrs. Dwight W. Morrow and John D. Rockefeller, Jr. 15 cents from Community Chests and Councils, 420 Lexington Ave., N.Y.C. Reductions on quantity orders.

Suggestions for training courses for board and committee members have been prepared for the Y.W.C.A. by Julia F. Capen and M. Esther Huckins. Womans Press, 600 Lexington Avenue, New York, price 75c.

Three bulletins on interpreting the social worker to the public are available from the Social Work Publicity Council, 130 East 22d Street, New York. They are:

Source Material on Competence in Social Work, 20c.

Public Opinion and the Social Worker, 20c.

Introducing the Social Worker to the Broader Public, 15c.

Fifty cents for set of three, reduction on quantity orders.

The establishment of a 16 mm. sound-on-film rental library with branches in various key cities is announced by Bell & Howell Company, Chicago. Approximately 100 reels from the Educational Film Corporation and other producers are now available in the library. Branches have been established in Altoona, Pa.; Denver; Washington, D. C.; Wilmington, Del.; Baltimore; New York; Philadelphia; Providence; Chicago; San Francisco, and Hollywood, Calif.

Suggestions for presenting social hygiene to student nurses either as a separate unit or integrated with other subjects are incorporated in *A Curriculum Study in Social Hygiene for Nurses* worked out by Mae D. McCorkle under the auspices of the National League of Nursing Education and the American Social Hygiene Association. From the National League of Nursing Education, 50 West 50th Street, New York. 65c.

Study outlines comprising nine lessons on "Communicable Diseases" have been prepared by the M.L.I. Company for the use of its nurses. Each lesson contains a list of questions and answers. Limited quantities of the outlines may be obtained without charge from the Metropolitan Life Insurance Company, 1 Madison Avenue, New York.

The Milbank Memorial Fund, 40 Wall Street, New York, is now charging a subscription price of $1.00 for its *Quarterly* and is supplementing it with a periodic *News Digest* which is distributed free of charge.

Food Customs from Abroad is the title of an unusually well-planned leaflet issued by the Massachusetts Department of Public Welfare, Boston. It includes a brief description of the background of each nationality, typical day's menus for each, an analysis of the strong and weak points in their food habits, and interesting bibliographies.

Those who have been following the reports on the *Effect of Unemployment on Children and Young People* made by the Save the Children International Union will want to see Part III, which gives the summary and conclusions of the various studies made in this country and in Europe. Without exception the reports from every country emphasize the seriousness of the harm done to children by the changed home atmosphere among the unemployed, particularly stressing the hazard to the family structure when the father is deprived of his place as the supporter of his children.

Equally as threatening is the unemployment of young persons just out of school. The interesting suggestion is made for the future of the possibility of lengthening the kindergarten period rather than adding an extra year at the other end, a procedure which is often too costly for most communities to bear. Fifty cents from the International Save the Children Fund of America, 156 Fifth Avenue, New York. $1.75 for the three Parts in one volume.

At the request of the National Council of Parent Education, Dr. Arnold Gesell of the Yale Psycho-clinic has recently released five new child development films through Erpi Picture Consultants. Sixteen millimeter silent prints of these films may be rented through the National Council of Parent Education, 60 East 42nd Street, New York. These films have been prepared especially for parent education groups meeting under emergency education leaders in connection with local emergency education programs. When not so used they are available to others at a rental of $1.50 per day per film, plus carrying charges. Each exhibitor is supplied with

one copy of the *Handbook for the Yale Films of Child Development* especially prepared by Dr. Gesell for use with these films.

Health and social workers have long realized the immensity of the occupational problem presented by the ex-sanatorium patient. Beulah Weldon Burhoe, Rehabilitation Secretary for the National Tuberculosis Association, presents in *The Social Adjustment of the Tuberculous* a summary of what is being done at the present time in rehabilitation projects, occupational therapy and adult education. She points out that the comparatively recent program of adult education and temporary employment in the sanatorium itself points the way toward a partial solution of the problem. Fifty cents from state tuberculosis associations or from the National Tuberculosis Association, 50 West 50th Street, New York.

The Physical Education and Athletics Section of the Los Angeles City School District has devised an effective health growth card. This little folder contains a record of the weight advance of the child from September to June by months and includes rules of health which are called "Rules of the Game." Inside in alphabet form is listed a series of nutritious breakfasts. This folder with the child's record of growth is sent home for the parent's signature with the report card and goes home for good with the June card. It is a potent reminder to the parent concerning his child's needs.

"Diabetes" is the subject of the April-May-June number of *The Commonhealth* (Boston). Among the various articles presented are:

The Heredity of Diabetes
Diabetic Camps
Social Problems Facing Diabetic Patients

A Health Manual for Seafarers has been prepared in French by the League of Red Cross Societies under the auspices of an international committee. It contains an alphabetical index of medical terms in English, French, German, Italian, Norwegian and Spanish. Copies may be obtained from the publishers: l'Agence Latine, 190, boulevard Haussman, Paris. Price 40 French francs.

A *Picture Book about the Costs of Medical Care* for popular consumption may be obtained free of charge from the Julius Rosenwald Fund, 4901 Ellis Avenue, Chicago.

RECENT PUBLICATIONS

FOOD, NUTRITION AND HEALTH. By E. V. McCollum and J. Ernestine Becker. Third edition (revised). Published by the authors, East End Post Station, Baltimore, Md. $1.50.

THE JOY OF LIVING. By Dr. Franklin H. Martin. An autobiography in two volumes. Doubleday, Doran and Co., Garden City, N. Y. $7.00. A well-known surgeon reviews his years of experience.

WOMEN WHO WORK. Grace Hutchins. International Publishers, New York. $2.00. What women are doing in various occupations as shown by the 1930 census.

EFFECTIVE INSTRUCTIONAL LEADERSHIP. Sixth Yearbook of the Department of Supervisors and Directors of Instruction, National Education Association. Bureau of Publications, Teachers College, Columbia University. Price $2.00.

HUMAN PROBLEMS OF AN INDUSTRIAL CIVILIZATION. By Elton Mayo. The Macmillan Company, New York. $2.00. Includes an interesting chapter on "The New Administrator."

HYGIENE OF THE MIND. Baron Ernst von Feuchtersleben. With an introduction by Esther Loring Richards. Macmillan. $1.25. A collection of essays by an Austrian physician.

YOUR MEALS AND YOUR MONEY. Gove Hambridge. Whittlesey House, McGraw-Hill Book Company, New York. $1.50. A practical interpretation of recent diet studies undertaken by the Bureau of Home Economics and presented in a readable and informal style.

A REVIEW OF NURSING. Helen F. Hansen, R.N. W. B. Saunders Company, Philadelphia. $3.00. A comprehensive review with questions and answers of subjects in the undergraduate curriculum.

MEDICAL DISEASES FOR NURSES. Arthur A. Stevens, M.D., and Florence Anna Ambler, R.N. Second edition. Saunders. $2.75.

PRINCIPLES AND PRACTICE OF NURSING. Bertha Harmer, R.N. Third edition. Macmillan. $3.00.

TEXTBOOK OF ANATOMY AND PHYSIOLOGY. Kimber, Gray, and Stackpole. Ninth edition. Macmillan. $3.00.

RECENT PAMPHLETS AND LEAFLETS

Eye Protection in Industry. A revised edition, including a self-appraisal for safety engineers and others concerned with the conservation of vision in industry. 5c. from the National Society for the Prevention of Blindness, 50 West 50th Street, N. Y.

Social Hygiene for Nurses. A classified list of materials especially selected for assistance to the nurse. Single copies free. American Social Hygiene Association or National Organization for Public Health Nursing, 50 West 50th Street, N. Y.

Noon Meals for Nursery Schools. By Helen Nebeker Hahn. Bureau of Home Economics, U. S. Department of Agriculture, Washington, D. C.

Women at Work. Bulletin No. 115, Women's Bureau, U. S. Department of Labor. For sale by the Superintendent of Documents, Washington, D. C. 5 cents. Traces the past and present condition of women in industry.

The Health Units of Boston. A graphic description of the growth of the health units established under the White Fund and now functioning as the strategic centers in Boston's health and welfare program. The Department of Health, Boston, Mass.

Give Your Heart a Chance. Prepared in coöperation with the American Heart Association. From the Metropolitan Life Insurance Co., 1 Madison Avenue, New York. Free.

Hospital Care in the Family Budget. A description of group hospitalization. C. Rufus Rorem. American Hospital Association, 18 E. Division St., Chicago. There are at the present time at least twenty towns and cities in the United States in which group hospitalization plans have been developed, with approximately sixty participating hospitals. Annual rates range from $6 to $12 per subscriber.

The Number and Distribution of Social Workers in the U. S. Ralph G. Hurlin. Russell Sage Foundation, New York, 10c.

Child Labor—Facts and Figures. U. S. Children's Bureau. For sale by the Superintendent of Documents, Washington, D. C. 10c.

Provisional Figures for Live Births, Infant Mortality, and Stillbirths, in Continental United States: 1933. Department of Commerce, Bureau of the Census, Washington, D. C.

A Study of Standards for Health Insurance. Edgar Sydenstricker. American Association for Social Security, Inc., 22 East 17th Street, New York.

Nursing Education and Practice in New York State with Suggested Remedial Measures. By Harlan H. Horner. An educator proposes some drastic measures to improve the present situation. University of the State of New York, Albany.

Work Relief in Germany. By Hertha Kraus. Russell Sage Foundation, 130 East 22d Street, New York. 50 cents. A well-written presentation by an experienced social worker of the work relief program in Germany. See also her article in this magazine, October, 1934.

Outline of Standards and Methods—Children's Health Service. New York Diet Kitchen Association, 595 Madison Avenue, N. Y. 40 cents plus postage.

The Twenty-ninth Year in Review. Milbank Memorial Fund, 40 Wall St., N. Y.

Problems of Health Conservation. Published proceedings of the twelfth annual conference of the Advisory Council of the Milbank Memorial Fund held at the N.Y. Academy of Medicine March 14 and 15. Of particular interest are the reports of the round tables on "Medical Care", "Public Health Nursing Studies" and "Childhood Tuberculosis". Milbank Memorial Fund, 40 Wall Street, New York.

Approximately 150 nurses from 25 states attended the annual meeting and institute of the National Association of Colored Graduate Nurses held at Meharry Medical College, Nashville, Tenn., August 14-17. The meetings were well attended, the papers interesting and the discussion thought-provoking. Mrs. Estelle Massey Riddle of Akron, Ohio, was elected president of the Association for the coming year.

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The Committee on Industrial Nursing of the Public Health Nursing Section of the Ohio State Nurses' Association recently made a state-wide survey of nurses employed in industrial plants, to ascertain if they were members of the S.N.A. and the N.O.P.H.N. Personal letters were written to non-members, inviting them to become members and to subscribe to PUBLIC HEALTH NURSING. This Committee will have a luncheon for industrial nurses at the 1934 annual meeting, at which Dr. Elliott, industrial physician for the International Harvester Co., will speak.

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The Statistical Report of Infant Mortality for 1933 (published by the American Child Health Association) reports that the birth and death registration areas are now complete in the United States so that for the first time since the compilation of these reports was begun in 1911 this report presents infant mortality data for every city of 10,000 population and over. Some of the outstanding points are:

The infant death rate in 985 cities of the Birth Registration Area is 57.1. Confining the 1933 data to the same 943 cities reported in the 1932 rate, the 1933 rate is 55.9, exactly .9 point lower than that for the preceding year. This is the lowest rate ever recorded in the history of the country.

The report states that: "It is practically certain that the maintenance of the present low rate of infant deaths or further reduction in the loss of our babies cannot result without continued effective medical and public health effort."

CORRECTION

The fourth biennial conference of the National Council of Parent Education will take place October 31-November 3, 1934, at the Wardman Park Hotel, Washington, D. C. The subject to be studied concerns a social philosophy of education in family life and parenthood. For further information write to the Council, 60 East 42d Street, New York.

RECENT APPOINTMENTS

Dorris Weber, Educational Director of the New Haven Visiting Nurse Association commencing January 1st, 1935.

N.O.P.H.N. NEWS

Unavoidable reductions in the N.O.P.H.N. income for 1935 have called for planning and action. Further curtailment of an already seriously reduced staff has seemed unthinkable to the Board of Directors in the light of constantly increasing demands and opportunities. Therefore, new money must be obtained even to keep going as at present.

Miss Katharine Deitz, who for many years has been associated with the National Board of the Y.W.C.A., came to the N.O.P.H.N. staff in September, as extension secretary, to assist in building a sound financial base for the maintenance of our national organization.

The Records Committee of the National Organization for Public Health Nursing has postponed issuing revised record forms until after January 1, 1935.